PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

Benefits discussed in this document include:

Medical Plan Options	**Basic Life Insurance and AD&D Insurance**	**Short Term Disability (STD)**
Dental Plan Options	**Supplemental Life Insurance**	**Long Term Disability (LTD)**
Vision Plan Options	**Commuter Benefit**	**COBRA**
Employee Assistance Program (EAP)		**Flexible Spending Account (FSA)**

Amended, Restated and Effective January 1, 2011

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INTRODUCTION

The City of Mesa strives to offer a variety of health care benefits to eligible participants. This Plan Document describes the wide variety of benefits available to eligible plan participants including medical, dental, vision, Employee Assistance Program (EAP) services, life insurance, short and long term disability, commuter death benefits, and flexible spending accounts.

The City self-insures and self-administers the Medical and Dental plans as well as the Flexible Spending Account program (including Health and Dependent Care Accounts). The City contracts with various insurers and organizations to provide the following services: Employee Assistance Program (EAP), Vision Plans, Life Insurance/AD&D, Supplemental (Voluntary) Life Insurance, Commuter Death benefit and Short and Long Term Disability.

The Plan described in this document is effective January 1, 2011 except for those provisions that specifically indicate other effective dates, and replaces all other plan document/summary plan descriptions previously provided to you. If you are not eligible for certain coverages then the chapters pertaining to those coverages do not apply to you. This plan is **not** subject to the provisions of the Employee Retirement Income Security Act, commonly called ERISA.

This document will help you understand and use the benefits provided by the City of. Please review it and share it with those members of your family who are or will be covered by the Plan. The Plan Document explains:

- the coverages provided;
- the procedures to follow in obtaining services and submitting claims; and
- your responsibilities to provide necessary information to the Plan Administrator.

Remember, not every expense you incur for health care is covered by the Plan.
The City of Mesa reserves the right to amend, modify, add or delete benefits to this Plan Document.

As the Plan is amended from time to time, the City will send you information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Questions You May Have:

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Benefits Plan Administrator at the phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the claims staff may respond informally to oral questions; however, oral/verbal communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Benefits Plan Administrator and obtain a written response from the Benefits Plan Administrator.

Spanish Language Assistance:

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con el Benefits Plan Administrator a la dirección y teléfono en el (Quick Reference Chart) de este documento.

IMPORTANT NOTICE

You and/or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other insurance coverage.

Failure to do so may cause you or your Dependents to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid on behalf of an ineligible person.

When you need information, please check this document first. If you need further assistance, please refer to the chart below:

QUICK REFERENCE CHART

Information Needed	Contact the following:
Benefits Claims Administrator • Plan Administrator • Group #: CM001 • Eligibility and Benefits Information • Medical and Dental claims administration • Flexible Spending Accounts • Medicare Part D Notice of Creditable Coverage • HIPAA Certificate of Creditable Coverage • COBRA Administration • ID Cards for Dental and Healthsmart Coverage	**Employee Benefits Administration Office** 20 E. Main St. Suite 600 Mesa AZ, 85201 *Mailing Address:* P. O. Box 1466 Mesa, AZ, 85211-1466 *Phone #:* **(480) 644-2299** *Office Hours*: M-TH: 7:00am to 6:00pm *E-mail Address*: BenefitsInfo@mesaaz.gov Website and Online Enrollment: www.mesachip.mesaaz.gov Intranet: http://insidemesa/benefits/default.aspx Claims should be submitted to : P.O. Box 1818, San Leandro, CA 94577
Medical Network Providers for plan participants who live in Arizona • Preferred PPO Network Providers	**Blue Cross and Blue Shield of Arizona (BCBSAZ)** **www.azblue.com** *Note:* Questions are handled by the Employee Benefits Administration Office at the number listed above.
Medical Network Providers for plan participants who live outside Arizona • Out of State Preferred PPO Network Providers • Group #: CM002	**HealthSmart/Beech Street PPO Network** 1-800-687-0500 Submit Claims to: HealthSmart Preferred Care P.O. Box 53010 Lubbock, TX 79453-3010 *Note:* Questions are handled by the Employee Benefits Administration Office at the number listed above.
Prescription Drug Program • ID Cards for the Medical plans • In-Network Retail Pharmacy locations • Home Delivery (Mail Order) Services • Direct Drug Reimbursement of non-network outpatient retail pharmacy claims • Preauthorization of certain prescription drugs • Specialty Drugs	**Medco Health** Member Services: **1-800-711-0917** **Home Delivery (Mail Order) Services**: • Doctor's fax instructions: 1-888-327-9791 • Patient phone refills: 1-800-473-3455 **Mail non-network outpatient retail pharmacy claims to:** Medco Health Solutions, Inc. P. O. Box 14711 Lexington, KY 40512 www.medco.com

QUICK REFERENCE CHART	
Information Needed	**Contact the following:**
Utilization Management (UM) • Precertification • Case Management • Medical review	**American Health Group (AHG)** 2152 S. Vineyard Ave, Suite 103 Mesa, AZ 85210 Phone #: (602) 265-3800 or 1-800-847-7605 Fax: 480-894-8105
Employee Assistance Program (EAP) • Up to eight (8) free counseling visits per patient per problem each EAP calendar year. • Eldercare and Childcare Referrals and Services • Legal Services	**EAP Preferred (Counseling and Family Resources)** (602) 264-4600 (press 2) or 1-800-327-3517 (press 2) www.eappreferred.com
Dental Plan	Contact the Employee Benefits Administration Office at 480-644-2299.
Vision Care Plan • Routine Vision Services • Vision network preferred providers • Vision claims and appeals	**VSP** Contact Member Services at 1-800-877-7195 5am to 7pm Pacific Time www.vsp.com Non-network vision claims should be sent to VSP Attn: Out of Network Claims P. O. Box 997105 Sacramento, CA 95899-7105
COBRA Administrator	Contact the Employee Benefits Administration Office at 480-644-2299.
Basic Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance	**CIGNA Life Insurance Company** Contact Employee Benefits Administration Office for questions or issues regarding this coverage at 480-644-2299.
Supplemental (Voluntary) Life Insurance	**CIGNA Life Insurance Company** Contact Employee Benefits Administration Office for questions or issues regarding this coverage at 480-644-2299.
Commuter Death Benefit	**Hartford Life Insurance** Contact the Employee Benefits Administration Office above.
Voluntary Short Term Disability (STD) Coverage	Contact Mutual of Omaha at 1(800) 877-5176 to file a claim or for customer service.
Long Term Disability	• Public Safety Personnel Retirement System administered by ~~**CIGNA**~~ **Insurance Company.** • Arizona State Retirement System administered by **Sedgwick CMS.** For questions contact the City's Employee Benefits Administration Office at (480) 644-2299.
Wellness	• CIGNA – Healthy Rewards at CIGNA.com/rewards | password: savings, or call at 1-800-258-3312 • Employee Wellness Resources at www.mesachip.mesaaz.gov
HIPAA Privacy Officer **HIPAA Security Officer**	Employee Benefits Administrator P.O. Box 1466 Mesa, AZ 85211-1466 Phone: (480) 644-2299

ELIGIBILITY

OVERVIEW OF ELIGIBILITY FOR PLAN BENEFITS					
Benefit Options	**Full-time Employees**	**Benefit Eligible Part-time Employees**	**Elected Officials**	**Retirees[1]**	**Retirees with Disability**
Medical Plans (a core benefit)	X	X	X	X	X
Dental Plans (a core benefit)	X	X	X	X	X
Vision Plans (a core benefit)	X	X	X	X	X
EAP	X	X	X		
Long Term Disability (LTD)	X	X			
Voluntary Short Term Disability (STD)	X				
Basic Life and AD&D Insurance	X			May port or convert to an individual policy	May continue through waiver of premium or port if not eligible for premium waiver
Supplemental Life Insurance	X	X	X		
Commuter Death Benefit	X	X	X		
Flexible Spending Accounts (FSA) (a core benefit)	X	X	X		

[1]: Note that employees hired on or after 1-1-09 are not eligible for retiree benefit coverage.

1. **Full time employees** of the City of Mesa who are regularly scheduled to work at least 40 hours or more each week, are eligible for the benefits listed on the chart above describing the Overview of Eligibility for Plan Benefits. Coverage for Core Benefits (medical, dental, vision and FSA plans) starts on the "benefit effective date" (defined in the chart below) as selected by the employee from the three options listed:

Option	Benefit Effective Date	Comments
Option 1	Date of hire	• Note that premiums will be prorated for medical and dental. • For vision benefits, if the date of hire is prior to the 15th of the month there will be no charge for the entire month's coverage, but if the hire date is on or after the 15th of the month, the premium must be paid for that entire month. • Enrollment forms and any required documentation such as marriage/birth certificate, divorce decree, etc. must be physically in the Employee Benefits Administration Office no less than three (3) working days prior to the benefit effective date. If this deadline is missed, the individual's coverage will be effective on the next available benefit effective date after receipt of the enrollment forms and documentation. Please note the Employee Benefits Office hours of operation and plan accordingly.
Option 2	First of the month following the date of hire	• Enrollment forms and any required documentation such as marriage/birth certificate, divorce decree, etc. must be physically in the Employee Benefits Administration Office no less than three (3) working days prior to the benefit effective date. If this deadline is missed, the individual's coverage will be effective on the next available benefit effective date after receipt of the enrollment forms and documentation. Please note the Employee Benefits Office hours of operation and plan accordingly.
Option 3	First of the month following one month of employment	• Enrollment forms and any required documentation such as marriage/birth certificate, divorce decree, etc. must be physically in the Employee Benefits Administration Office no less than three (3) working days prior to the benefit effective date. If this deadline is missed, the individual's coverage will be effective on the next available benefit effective date after receipt of the enrollment forms and documentation. Please note the Employee Benefits Office hours of operation and plan accordingly.

All other benefits (including Basic Life and AD & D Insurance, Voluntary/Supplemental Life Insurance, Voluntary Short Term Disability) will be effective on the first of the month following the completion of one month of employment. Benefits enrollment includes the fact that proper enrollment forms have been completed and submitted to the Employee Benefits Administration Office and you pay any required premium contribution.

2. **Part time employees of the City of Mesa** who are working at least 20 hours per week on a regular basis (year-round in a benefits-eligible part time position) are eligible for the benefits listed on the chart above describing the Overview of Eligibility for Plan Benefits. Coverage for benefits starts on the first day of the month after you have been employed for 6 months as long as the proper enrollment forms have been completed and submitted to the Employee Benefits Administration Office and you pay any required premium contribution.

3. **Elected Officials of the City of Mesa** (Mayor, City Councilmembers) are eligible for the benefits listed on the chart above describing the Overview of Eligibility for Plan Benefits. Coverage for these benefits starts on the day on which you are sworn into office as long as the proper enrollment forms have been completed and submitted to the Employee Benefits Administration Office and you pay any required premium contribution.

4. **Retired employees (retirees) of the City of Mesa** who meet the eligibility requirements as stated in this chapter, and begin receiving and continue to receive retirement benefits either from the Arizona State Retirement System (ASRS) or Public Safety Personnel Retirement System (PSPRS) on the first of the month following retirement with the City of Mesa, are eligible for the benefits described on the chart above describing the Overview of Eligibility for Plan Benefits. The monthly premium paid by the retiree depends upon the coverage chosen and the number of years of service with the City of Mesa. Coverage begins on the first day of the month following the employee's retirement date, as long as you pay any required contribution. Retired employees and their eligible dependents must enroll in Medicare Parts A and B upon becoming eligible. Note that employees hired on or after 1-1-09 are not eligible for retiree benefit coverage.

5. **Retired employees (retirees) with Disability:** Retired employees, other than those listed above, who have retired from employment due solely to a disability **and** are receiving a LTD benefit **and** who continue to meet the requirements of disability as defined in the Definitions chapter of this document, are also eligible for the same Plan coverage as retired employees without a disability. See the benefits described on the chart above describing the Overview of Eligibility for Plan Benefits. An employee will be allowed to retire under this provision if totally disabled for a period of at least six months. Coverage begins on the first day of the month following the retirement date, as long as you pay any required contribution. Individuals who retire due to a disability must enroll in Medicare Parts A and B upon becoming eligible. Note that employees hired on or after 1-1-09 are not eligible for retiree benefit coverage.

YOUR DEPENDENTS' ELIGIBILITY FOR COVERAGE

If you elect coverage for yourself, you are also eligible for the same benefit coverages for your Eligible Dependents on the later of the day you become eligible for your own medical coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment form which can be obtained from the Employee Benefits Administration Office or the City's Intranet **and** pay any required contributions for covered Dependents **and** if benefit coverage is in effect for you on that day.

1. Your Eligible Dependents include your lawful Spouse (as defined by Arizona state law) and your Dependent Child(ren) as those terms are defined in the Definition chapter of this document.

2. Anyone who does not qualify as a Dependent Child or Spouse as those terms are defined by this Plan has no right to any coverage for Plan Benefits or services under this Plan.

3. For dependents of retirees, the appropriate premium must be paid by the 15th of each month or the dependent coverage will be terminated.

SURVIVING LAWFUL SPOUSE AND SURVIVING DEPENDENT(S) – Harrolle's Law

The surviving lawful spouse and surviving dependent(s) of a deceased City law enforcement officer are entitled to continue health coverage under the Plan for **up to one (1) year after the death of the law enforcement officer**. The following terms apply:

a. the law enforcement officer: (1) must have been killed in the line of duty; or (2) must have died from injuries suffered in the line of duty; and

b. the law enforcement officer must have been enrolled in a City-sponsored medical plan at the time of death; and

c. the surviving lawful spouse and surviving dependents must have been covered by a City-sponsored medical plan at the time of the officer's death; and

d. premiums for coverage must be paid by the surviving lawful spouse and surviving dependents at the same rate that applies to active employees and their families; and

e. upon termination of coverage, the surviving lawful spouse and surviving dependent(s) will have the opportunity to elect temporary COBRA continuation of coverage.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status will be required by the Plan and may include any of the following:

- **Marriage:** copy of the certified marriage certificate.
- **Birth:** copy of the certified birth certificate.
- **Natural son or daughter:** birth certificate listing employee/retiree as parent, child's marriage certificate (if child is married and has had a name change), copy of health insurance card if the child has coverage under any other health plan including Medicare, Medicaid, AHCCCS, or any employer health plan.
- **Adoption or placement for adoption**: birth certificate; adoption or placement documentation listing employee/retiree or spouse as adoptive parent; if child is married and has had a name change, child's marriage certificate; copy of health insurance card if child has coverage under any other health plan including Medicare, Medicaid, AHCCCS, or any employer health plan
- **Stepchildren**: birth certificate showing the employee's/retiree's spouse as the parent; if child is married and has had a name change, child's marriage certificate; employee's/retiree's marriage certificate documenting marriage to stepchild's parent; copy of health insurance card if child has coverage under any other health plan including Medicare, Medicaid, AHCCCS, or any employer health plan.
- **Foster Children:** birth certificate; if child is married and has had a name change, child's marriage certificate; foster care license & placement documentation listing employee/retiree or spouse; copy of health insurance card if child has coverage under any other health plan including Medicare, Medicaid, AHCCCS, or any employer health plan.
- **Grandchildren:** birth certificate; if child is married and has had a name change, child's marriage certificate; legal guardianship documentation listing employee/retiree or spouse as legal guardian; copy of health insurance card if child has coverage under any other health plan including Medicare, Medicaid, AHCCCS, or any employer health plan.
- **Legal Guardianship:** a copy of your legal guardianship documents and a copy of the certified birth certificate.
- **Involuntary loss of Dependent coverage:** Certificate of coverage from previous employer and marriage certificate if not already on file.
- **Disabled Dependent Child:** The plan requires Social Security Disability documentation as proof of disability status.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document or National Medical Support Notice.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Plan Administrator, or its designee, the **Social Security Number (SSN)** of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have dis-enrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Failure to provide the SSN means that claims for eligible individuals cannot be processed for the affected individuals.

As a reminder, retired employees and/or their dependents MUST enroll in Medicare Parts A and B upon becoming eligible for said coverage.

Enrollment in Medicare Part D is optional; however, when a retired employee or dependent elects Medicare Part D through a Prescription Drug Plan (PDP), that plan will become the primary payer for prescription coverage and the City of Mesa will coordinate benefits with that PDP. Enrollment in Medicare or disenrollment from a Medicare Part D Prescription Drug Plan must be reported to the Plan Administrator.

EMPLOYEE ASSISTANCE PROGRAM (EAP) ELIGIBILITY

All employees and their family members are eligible to use the EAP program sponsored by the City of Mesa. You do not have to be enrolled in one of the City-sponsored health insurance plans to use the services available through the EAP. The EAP is described in the EAP chapter of this document.

ENROLLMENT FOR AND START OF COVERAGE

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special Enrollment, and Open Enrollment. These opportunities are described further in this chapter.

Procedure to Request Enrollment:

Generally an individual must call, fax, e-mail or walk into the Employee Benefits Office and indicate their desire to enroll in the Plan. Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll at that time will be announced by the Plan at the beginning of the Open Enrollment period.

Once enrollment is requested, you will be provided with **the steps to enroll** that include all of the following:

a. submit a completed written or electronic enrollment form (which may be obtained from and submitted to the Employee Benefits Office), and
b. provide proof of Dependent status (as requested), and
c. pay any required contributions for coverage, and
d. perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, or Open Enrollment provisions of this Plan.

Enrollment Is Required for Coverage:

You and your Eligible Dependents may become covered under the benefits of this Plan **only** upon submission of a completed written enrollment form which may be obtained from and submitted to the Employee Benefit Administration Office, including any other required documentation such as birth or marriage certificate, and by paying any required contributions for coverage. A person who is not duly enrolled by submitting a completed written enrollment form and paying any required contributions has no right to any coverage for Plan Benefits or services under this Plan.

Declining (Opting Out of or Waiving) Medical, Dental and/or Vision Coverage:

As an employee, you may decline medical, dental and/or vision coverage under this Plan. To do so, you must complete and submit an enrollment form with the opt-out provision indicated to the Employee Benefits Administration Office and, if you are a full-time employee, present evidence that you are covered under another medical and/or dental plan (such as the health insurance ID card or enrollment form). Part-time benefit eligible employees are not required to show proof of other coverage to opt out of the coverage through the City of Mesa.

Note that no additional compensation is paid to you if you waive/decline/opt-out of benefit coverage. If you decline coverage for yourself, you will **not** be allowed to enroll your spouse or dependent children in the coverage you decline.

If, at a later date, you want to reinstate the coverage you declined you may enroll yourself and any eligible dependents **only** under the Special Enrollment provisions (when applicable) or the Open Enrollment provisions described later in this chapter.

Eligible retirees may also decline/opt-out of medical, dental and/or vision coverage by completing and submitting an enrollment form with the opt-out provisions elected, to the Employee Benefits Administration Office. Retirees are not required to show evidence of other coverage before exercising this opt-out option. If you decline coverage for yourself, you will **not** be allowed to enroll your spouse or dependent children under the coverage you declined. **Once a retiree opts-out of a coverage option under this Plan, the retiree may never re-enroll in any such City-sponsored program again.** For example, if the retiree opts out of medical coverage and keeps dental coverage, the retiree may never re-enroll in any City-sponsored medical plan but may continue with the dental plan from year to year. Note that no compensation is made to a retiree if the retiree waives/declines/opts out of benefit coverage.

INITIAL ENROLLMENT

1. **Initial Enrollment Period and Procedure:** You must enroll no later than 31 days after the date on which you are eligible for coverage by submitting a completed written enrollment form which may be obtained from the Employee Benefits Administration Office. If you want Dependent coverage, you must enroll your Eligible Dependents at the same time. This Plan **does not** apply a pre-existing condition limitation.
2. **Rehired/Reinstated Individuals:**
   - **If you cease to be covered under this Plan and then within thirty 30 days return to work with the City in a benefits-eligible position**, then you will be required to take the same benefit election for the remaining portion of the

Plan year as you had before you terminated. Participation will be effective the first of the month following such election.

- **If you cease to be covered under this Plan and return to work with the City in a benefits-eligible position more than 30 days** following the termination you will be considered a new hire and must follow the Initial Enrollment provisions of this Plan.
- **Special rules pertaining to Reduction in Work Force (RIWF**): Effective January 1, 2009, employees who are officially laid off from the City of Mesa OR who, as a result of a position being targeted for lay-off, elected to take an early retirement in lieu of being laid off AND who are reinstated as employees within two years from their last day worked, will have the following apply for purposes of determining retiree health insurance eligibility:
  - the employee's last prior employment effective date with the City of Mesa will be reinstated to determine the number of years of service required for that employee to qualify for retiree benefits with the City and
  - the employee's prior years of service with the City of Mesa (including partial years) will be reinstated and used as credit toward the City's years of service requirement for determining eligibility and family premium amount.

  These provisions will not apply to City of Mesa employees who voluntarily separate from the City of Mesa.

3. **Start of Coverage Following Initial Enrollment:**
   - **For Full-time employees**, your coverage starts on your "benefit effective date" The definition of "benefit effective date" is outlined at the front of this chapter under Full-time employees. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.
   - **For Elected Officials,** your coverage starts on the day on which you are sworn into office. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the day your coverage begins.
   - **For Part-time employees,** your coverage starts on the first day of the month after you have been employed by the City of Mesa for 6 months. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.
   - **For Retired employees and retirees with disability,** your coverage starts on the first day of the month following the employee's retirement date. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins. Note that employees hired on or after 1-1-09 are not eligible for retiree benefit coverage.
4. **Failure to Enroll During Initial Enrollment**: If you do not enroll your Eligible Dependents during the Initial Enrollment period, (unless your Eligible Dependent(s) qualify for the Special Enrollment described in the following section), you will **not** be able to enroll them until the next Open Enrollment period.

SPECIAL ENROLLMENT

1. **Newly Acquired Spouse and/or Dependent Child(ren) (as these terms are defined under this Plan)**:
   - If you are enrolled for individual coverage and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may request enrollment for your newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.
   - If you did not enroll your Spouse for coverage within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may request enrollment for your Spouse together with your newly acquired Dependent Child no later than 31 days after the date of your newly acquired Dependent Child's birth, adoption or placement for adoption.
   - To request Special Enrollment follow the Enrollment procedures described earlier in this chapter. Enrollment forms may be obtained from the Employee Benefits Administration Office. Supporting documentation, including birth/marriage certificates for your newly acquired dependents may be submitted along with your Enrollment form, or at a later date if not available within 31 days after the date of marriage, birth adoption or placement for adoption. To obtain more information about Special Enrollment, contact the Employee Benefits Administration Office.
2. **Loss of Other Coverage**:

   If you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within 31 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, or other public program; **and** you, your Spouse and/or any Dependent Child(ren) cease to be covered by that other health insurance policy or plan; you may request enrollment for yourself, that Spouse and/or Dependent Child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan if that other coverage terminated because:

- of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- of termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was "exhausted" or
- of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- of the other plan ceases to offer coverage to a group of similarly situated individuals; or
- of the loss of dependent status under the other plan's terms; or
- of the termination of a benefit package option under the other plan, unless substitute coverage offered; or
- of the loss of eligibility due to reaching the benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

See also the Enrollment Procedures section of this chapter for more information. Proof of loss of coverage is required by this Plan. Loss of coverage does not apply to Retirees and their dependents.

COBRA Continuation Coverage is "Exhausted" if it ceases for any reason **other than** either the failure of the individual to pay the applicable COBRA premium on a timely basis, **or** for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

3. You and your dependents may also enroll in this Plan if you (or your eligible dependents):
   a. have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan **within 60 days** after the Medicaid or CHIP coverage ends; or
   b. become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan **within 60 days** after you (or your dependents) are determined to be eligible for such premium assistance.
4. **Start of Coverage Following Special Enrollment**: If a request for enrollment has been submitted on a timely basis:
   - Except with respect to coverage of a newborn or newly adopted Dependent Child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren) will become effective on the first day of the month preceding or following (as you choose) the date the Plan receives the request for enrollment. (See the Enrollment Procedures outlined earlier in this chapter).
   - If the individual requests Special Enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
   - Coverage of a newborn or newly adopted Dependent Child who is enrolled within 31 days after birth will become effective as of the date of the child's birth.
   - Coverage of a newly adopted Dependent Child who is enrolled within 31 days after birth will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
   - Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated employees at Initial Enrollment. This also means that for individuals enrolled during a Special Enrollment opportunity, the employee will be permitted to change benefit plan options if desired.

5. **Failure to Enroll During Special Enrollment:** If you fail to request enrollment for any of your Eligible Dependents within 31 days (or as applicable 60 days) after the date on which they first become eligible for Special Enrollment, you will not be able to enroll them until the next Open Enrollment period.

OPEN ENROLLMENT

1. Open Enrollment is the period of time during the fall of each year (to be designated by the City) during which eligible employees, retirees and COBRA participants may add or drop certain benefits, add or drop dependents or switch between different health plan options offered by the City. The Employee Benefits Administration Office will notify eligible participants of the choices and options available during an Open Enrollment period.

2. **Restrictions on Elections During Open Enrollment**:

   - No Dependent may be covered unless you are covered.
   - You and all your covered Eligible Dependents must be enrolled for the same medical and dental coverages. For example, you must all be covered in the same Medical Plan option.
   - All relevant parts of the enrollment form (whether completed on paper or via the electronic Open Enrollment system) must be completed and the form must be submitted **and received before the end of the Open Enrollment period**.
   - All required Proof of Dependent Status documentation (including birth/marriage certificates if not previously submitted, etc.) must be submitted to the Employee Benefits Administration Office BEFORE the beginning of the Plan Year for which enrollment has been requested. Failure to submit such documentation will result in the dependent NOT being enrolled.
   - Retirees who have opted out of a particular coverage will not be able to re-enroll during any Open Enrollment period or at any time.

3. **Start of or Changes to Coverage Following Open Enrollment:** If you or your Spouse or Dependent Child(ren) are enrolled for the first time during an Open Enrollment period, that person's coverage will begin on the first day of the Plan Year following Open Enrollment. All other changes in or discontinuance of coverage will become effective on the first day of the Plan Year following Open Enrollment.
4. **Failure to Make a New Election During Open Enrollment:** If you are an active employee and have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be automatically enrolled in the default plan and coverage level designated by the Plan Administrator. Retirees and COBRA participants will be enrolled in the same coverage in which they are currently enrolled for the new plan year.
5. **Failure to Enroll During Open Enrollment:** If you fail to enroll any of your Eligible Dependents within the Open Enrollment time period specified by the Employee Benefits Administration Office, unless your Eligible Dependents qualify for Special Enrollment described in the previous section, you will not be able to enroll them until the next Open Enrollment period.

LATE ENROLLMENT

There are **no late enrollment provisions under this Plan**. The Plan offers an annual Open Enrollment period as described earlier in this text.

NEWBORN Dependent Children (Special Rule for Coverage)

Your newborn Dependent Child(ren) will be covered from the date of birth, **provided** you request enrollment for that newborn Dependent Child for coverage **within 31 days** after the child's date of birth by completing the written enrollment form available in the Employee Benefits Administration Office or on the Intranet and you show proof of dependent status (as requested) **and** you pay any required contribution for that Dependent Child's coverage.

Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child is not considered proper enrollment of that child for coverage under this Plan.

ADOPTED DEPENDENT CHILDREN (Special Rule for Coverage)

Your adopted Dependent Child will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- A Newborn Child who is Placed for Adoption with you within 31 days after the child was born will be covered from the date the child was born if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.

- A Dependent Child adopted more than 31 days after the child's date of birth will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you submit a completed written enrollment form to the Employee Benefits Administration Office and provide of proof of Dependent status (as requested) and pay any required contribution for that Dependent Child's coverage, within 31 days of the child's adoption or placement for adoption.

If the adopted Dependent child is not properly enrolled in a timely manner, you must wait until the next Open Enrollment period or Special Enrollment period, if applicable. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and Enrollment Procedure in this chapter.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR THE CITY (Special Rule for Enrollment)

1. **If both you and your Spouse are eligible employees of the City**, you may either elect your own individual (single) plan coverage, or elect one family plan for both you and your spouse and your eligible dependent children. The employee enrolled as the spouse of another employee may opt out of coverage. If both you and your Spouse are eligible employees of the City and each elect different medical plan coverage and one of you has a reduction in hours causing you to lose eligibility for coverage you should immediately contact the Employee Benefits Administration Office.

2. If, while your family coverage is in effect, any of your **Dependent Children becomes an employee of the City** and becomes eligible for coverage as an employee that child will cease to be a Dependent Child, and may enroll for coverage as an employee, in which case coverage as a Dependent Child will terminate as of the date coverage as an employee begins. If the employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the employee-child can be covered under the parent's coverage **ONLY if** a new enrollment form is completed and submitted along with any required contribution, to the Employee Benefits Administration Office.

3. **If both you and your spouse were employed by and retired from the City of Mesa**, you may either elect your own individual (single) plan coverage or one family plan as described in #1 above. If the individual designated as the retiree precedes the spouse in death, the spouse may enroll in his/her own single coverage plan (or family if other dependents are to be covered as well).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs) (SPECIAL RULE FOR ENROLLMENT)

1. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent.

2. A QMCSO usually results from a divorce or legal separation and typically:
   - Designates one parent to pay for a child's health plan coverage;
   - Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
   - Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
   - States the period for which the QMCSO applies; and
   - Identifies each health care plan to which the QMCSO applies.

3. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

4. If a court or state administrative agency has issued an order with respect to health care coverage for any of the employee's Dependent Children, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the employee is covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren).

5. If the employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan

will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the employee, retiree or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, insofar as is permitted by applicable law.

6. If the employee is **not** a participant in the Plan at the time the QMCSO is received **and** the QMCSO orders the employee to provide coverage for the Dependent Child(ren) of the employee, the Plan will accept a Special Enrollment of the employee and the Dependent Child(ren) specified by the QMCSO. Coverage of the employee and the Dependent Child(ren) will become effective as of the first day of the month following the date the enrollment is received by the Plan along with any required contribution, at the Employee Benefits Administration Office.

7. No coverage will be provided for any Dependent Child under a QMCSO unless the applicable employee contributions for that Dependent Child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent Child have been satisfied.

8. Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. For additional information regarding the procedures for payment of claims under QMCSOs, see the Claims Information chapter of this document or contact the Employee Benefits Administration Office.

PAYMENT FOR YOUR COVERAGE

Your contributions pay part of the cost of coverage for yourself and your dependents. The City pays the rest. The amount that you and the other employees and retirees pay for this coverage is based on the cost of the Plan for all of the people that it covers with variations for the types of coverages chosen and whether you cover your dependents.

CHANGING YOUR COVERAGE DURING THE YEAR (Mid-Year Change in Status)

Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year (from January 1 through December 31), but you may be able to make some changes during the year if the Plan Administrator or its designee determines that you have a qualifying change in your status **affecting your benefit needs**. The following qualifying changes are **the only ones** permitted under the Plan:

1. Change in employee's legal marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;

2. Change in number of employee's Dependents, including birth, adoption, placement for adoption, or death of a Dependent Child;

3. Change in employment status or work schedule IF it impairs your, your Spouse's or your Dependent Children's eligibility for benefits, including the start or termination of employment by you, your Spouse or any Dependent Child, or an increase or decrease in hours of employment by you, your Spouse or any Dependent Child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change of work-site;

4. Change in Dependent status under the terms of this Plan that satisfies or ceases to satisfy the Plan's eligibility requirements, including changes due to attainment of age or any other reason provided under the definition of Dependent in the Definitions chapter of this document;

5. Change of residence or worksite that allows or impairs your, your Spouse or any Dependent Child's ability to continue benefits under the coverages you have chosen;

6. Change required under the terms of a Qualified Medical Child Support Order (QMCSO), including a change in your election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage;

7. Change consistent with your right to Special Enrollment as described in the paragraph on Loss of Other Coverage in the section dealing with Special Enrollment.

8. Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.

9. Change in cost of coverage.
   a. **Automatic increase or decrease in your contributions for coverage** under any of your employer's Health Care Plan options as a result of a change in the cost of coverage for all Plan participants, or as a result of a change in the number of your covered Dependents or a permitted mid-year change to another of your employer's Health Care Plan options, if the

increase or decrease in contributions is or would be required from all similarly-situated employees. The Plan may automatically increase or decrease contributions on a reasonable and consistent basis.

b. **Significant increase or decrease in your contributions for coverage** under your employer's Health Care Plan options or your Spouse's employer's health care plans or programs. In such a case you may start coverage in the plan option with the decreased cost; or, revoke coverage in the plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.

10. **Significant changes in coverage.**
    a. **Significant curtailment**. If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
    b. **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

11. **Changes in Spouse's, Former Spouse's or Dependent's coverage.** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of your Spouse, Former Spouse or Dependent for one of the following reasons:
    a. If the change is permitted under federal cafeteria plan regulations; or
    b. If the plan of the Spouse, Former Spouse, or Dependent's employer permits participants to make an election for a period of coverage that is different from the Plan Year under this Plan.
12. **Addition or significant improvement of any Plan option** under the employer's Health Care Programs or your Spouse's employer's health care plans or programs. In such a case you may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.

These rules apply to making changes to your benefit coverage(s) during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to <u>be necessary, appropriate to and consistent with the change in status</u> (for example, if mid-year, the employee and spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the spouse from coverage at this time) and
2. You must notify the Plan in writing within 31 days of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage; and
3. If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. <u>Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan</u>; and
4. Coverage changes associated with a mid-year qualifying change of status opportunity **must be prospective** and therefore are effective the first day of the month following the qualifying change provided you submit a completed written enrollment/change form to the Employee Benefits Office, except for:
    - Newborns, who are effective on the date of birth;
    - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.
5. Except in situations where there is a change in plan costs, or a Special Enrollment opportunity, employees cannot change from one plan option to another plan option mid-year and must wait until Open Enrollment to change plans.

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted medical plan changes and is not all inclusive.
This chart should NOT be referenced for the Health FSA or Dependent Care Account Plan (DCAP).

If you experience the following Event...	You may make the following change(s)* within 31 days (where applicable 60 days) of the Event…	YOU MAY NOT make these types of changes...
Family Events		
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible dependents • Drop health coverage (to enroll in your Spouse's plan) • Change health plans, when options are available	• Drop health coverage and not enroll in Spouse's plan; if you do, you won't receive coverage.
Divorce	• Remove your Spouse from your health coverage • Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and eligible spouse • Change health plans, when options are available	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (*e.g.*, child reaches the maximum age for coverage)	• Must remove the child from your health coverage • Child will be offered COBRA.	• Change health plans • Drop health coverage for yourself or any other covered individuals
Death of a dependent (Spouse or child)	• Remove the dependent from your health coverage • Change health plans, when options are available	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicaid or Medicare	• Drop coverage for the person who became entitled to Medicare or Medicaid. • Add the person who lost Medicare/Medicaid entitlement.	• Drop health coverage for yourself or any other covered individuals
Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	• Remove your Spouse from your health coverage, with proof of other plan coverage • Remove your children from your health coverage, with proof of other plan coverage • Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan	• Change health plans • Add any eligible dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan • Change health plans, when options are available	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment.		

If your coverage terminates because you have a qualifying change in status resulting from loss of your job or switching to a job position which is not eligible for benefits**, and** if you do not elect to have COBRA continuation coverage described in the COBRA chapter, **and** your position status becomes benefit-eligible, you must re-enroll for coverage under this Plan by following the Initial Enrollment provisions discussed in this chapter.

Special rules, discussed in the section of this chapter on Special Circumstances, apply if you let your coverage lapse while you are on Family or Medical Leave or on Leave for Military Service.

WHEN COVERAGE ENDS (Events Causing Coverage to End):

1. **Employee coverage** ends on the earliest of the **last day of the month** in which:
   - your employment ends; or
   - you are no longer eligible to participate in the Plan; or
   - you cease to make any contributions required for your coverage; or
2. the City terminates the Plan**Dependent coverage** ends on the earliest of the **last day of the month** in which:
   - your own coverage ends; or
   - your covered Spouse or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren); or
   - you cease to make any contributions required for their coverage; or

   the City terminates the Plan**NOTE:** For the first 6 months following the death of an employee, dependents who were covered under any health Plan offered by the City may elect COBRA and the first six months of COBRA coverage will be provided by the City at the same contribution rate for either single or family coverage as the Plan in place when the employee was covered (excludes Harrolle's Law).
3. **Retiree coverage** ends on the earliest of the **last day of the month** in which:
   - The retiree is no longer eligible as defined in this plan (i.e. no longer receiving either an LTD benefit or a benefit from the Arizona State Retirement System (ASRS) or Public Safety Personnel Retirement System (PSPRS); or
   - you cease to make contributions required for coverage; or
   - the City terminates the Plan.

   NOTE: For the first 6 months following the death of a retiree, dependents who were covered under any health Plan offered by the City may elect COBRA and the first six months of COBRA coverage will be provided by the City at the same contribution rate for either single or family coverage as the Plan in place when the retiree was covered (exludes Harrolle's Law).
4. **Surviving Lawful Spouse and Surviving Dependents coverage ends on the earliest of the last day of the month** in which:
   - the surviving lawful spouse and dependents are no longer eligible to participate in the Plan (includes circumstances in which: (1) the 12 months of coverage for the surviving lawful spouse and dependents is exhausted; and (2) the surviving dependents no longer meet the definition of Dependent Child(ren) as provided in the Definitions chapter of this document); or
   - the surviving lawful spouse and surviving dependents cease to make the contributions required for coverage; or
   - the City terminates the Plan.

COVERAGE ELECTIONS FOR RETIREES

Regular Retirement: If an active employee is planning to retire from the City the active employee's coverage will terminate and the individual will be offered the opportunity to elect COBRA coverage or the City's retiree coverage under the same health plan coverage that they had as an active employee.

Medical Retirement: An active employee who is unable to work because of a disability and who loses their eligibility under the health plan will have the following options: to elect COBRA coverage or if the individual is planning to take a Medical Retirement from the City or is approved for Long Term Disability (LTD) benefits and is currently enrolled in one of the City's health plan coverages, that individual may elect the City's retiree coverage under the same health plan coverage that they had as an active employee. However, if that active employee had opted out of health plan coverage as an active employee, there will be no opportunity to elect COBRA and instead the individual can elect to enroll in one of the health plan coverages as a retiree.

There is no opportunity to elect the City's retiree coverage or COBRA coverage if either of these coverages is declined when first offered.

REQUIRED PLAN NOTIFICATION

You, your Spouse, or any of your Dependent Children must notify the Plan **preferably within 31 days but no later than 60 days** after the date of:

- a divorce;
- a Dependent Child reaches the Plan's limiting age (see the definition of Dependent in the Definitions chapter); or
- a Dependent Child who is physically or mentally disabled; or ceases to have any physical or mental Disability.

Failure to notify the Plan of the above noted events may jeopardize future COBRA rights. See the section on Information You or Your Dependents Must Furnish to the Plan in the Other Information chapter of this document for information regarding other notices you must furnish to the Plan.

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE

A. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:

   1. **engages in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
   2. **allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
   3. **altered any prescription** furnished by a Physician or other Health Care Practitioner.

   If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

B. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 15 days after it gives you written notice of its finding that you have failed to pay your premium payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period.

LEAVES OF ABSENCE

Family and/or Medical Leave:

a. If you have completed 12 months of employment, you are entitled by law to up to 12 weeks each year (in some case up to 26 weeks) of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. For the calculation of the 12-month period used to determine employee eligibility for FMLA, this Plan uses a rolling 12-month period measured backwards in time from the date the employee uses any FMLA leave.

b. The City will continue plan contributions for the employee on the same basis as prior to the beginning of the leave. The employee will be responsible for making any required monthly dependent contributions. While you are officially on such a Family or Medical Leave, you can keep benefit coverages for yourself and your Dependents in effect during that Family or Medical Leave period by continuing to pay any required contributions.

c. Since you **may not be paid** while you are on Family or Medical Leave, you may pay your contributions as they come due on the dates you would have been paid or on some other schedule agreed to by you and the Employee Benefits Administrator, in which case your contributions will be made on an after-tax basis.

d. Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that Leave, your benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your Leave. This is also true for any of your Dependents who were covered by the Plan at the time you took your Leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that Leave will apply to you and your Dependents in the same way they apply to all other employees and their Dependents.

e. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact Human Resources.

Leave for Military Service:

If you go into active military service **for up to 31 days**, you can continue your health care coverage under this Plan during that leave period if you continue to pay your contributions for that coverage during the period of that leave. If you go into active military service **for more than 31 days**, you should receive military health care coverage at no cost; however, you may also continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

- If you elect USERRA continuation coverage on or after December 10, 2004 the maximum period for this coverage is up to 24 months (unless a City of Mesa Management Policy extends this minimum time period).

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA chapter of this document.

Questions regarding your entitlement to USERRA leave, whether USERRA continuation coverage is extended by a City of Mesa Management Policy and general information on COBRA and USERRA continuation of health care coverage should be referred to the Employee Benefits Administration Office or refer to Management Policy #338 on Military Leave.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

If your coverage ends while you are on an approved leave of absence for family, medical or military leave, your coverage will be reinstated on the day you return to active service, if you return immediately after your leave of absence ends, subject to all accumulated Overall and Annual Maximum Benefits that were incurred prior to the leave of absence.

Questions regarding your entitlement to an approved leave of absence and to the continuation of benefit coverage should be referred to the Employee Benefits Administration Office.

CONTINUATION OF CERTAIN BENEFIT COVERAGES

There is no extension of benefits provision under this Plan. See the chapter describing COBRA for an explanation of when and how you may continue your coverage.

HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When your medical coverage ends, you and/or your covered Dependents are entitled by law to and will automatically be provided with, a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. In addition, such a certificate will be provided upon receipt of a request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended. See the chapter describing COBRA for an explanation of when and how those certificates of coverage will be provided.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended under this Plan. The written request must be mailed or faxed to the Plan Administrator and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address and fax of the Plan Administrator (in care of the Benefits Claims Administrator) is on the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

MEDICAL PLANS

THE MEDICAL PLAN OPTIONS

The City offers four Medical Plan Options to plan enrollees, described below. You and all your family members who are enrolled for medical coverage must all be enrolled in the same plan option.

- **Choice PPO Plan:** This plan option is a coinsurance plan allowing you to use either in-network or out-of-network providers. The in-network providers are Preferred (PPO) providers as defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.
- **Choice Plus PPO Plan**: This plan option is a coinsurance plan allowing you to use either in-network or out-of-network providers with some additional benefits not available in the other plan options. The in-network providers are Preferred (PPO) providers as defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.
- **Basic Choice PPO Plan**: This plan option is a coinsurance plan allowing you to use either in-network or out-of-network providers. Coverage is limited and certain types of services are not covered under this Plan. The in-network providers are Preferred (PPO) providers defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.
- **Copay Choice Plan**: This plan option uses copayments for many services provided by in-network providers and coinsurance for out-of-network providers. The in-network providers are Preferred (PPO) providers as defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called Eligible Medical Expenses, and they are limited to those that are:

1. determined by the Plan Administrator or its designee to be "Medically Necessary" and "Contracted Charges" or "Allowed Charges**"** as those terms are defined in the Definitions chapter of this document; **and**
2. not services or supplies excluded from coverage as provided in the Exclusions chapter of this document; **and**
3. not in excess of any applicable General Overall, Limited Overall, and/or Annual Maximum Plan Benefits that are shown in the Schedule of Medical Benefits.

NON-ELIGIBLE MEDICAL EXPENSES EXPLAINED

The Plan will **not reimburse you** for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary; that are determined to be in excess of the Allowed or Contracted Charges; that are not covered by the Plan; or that are determined to be in excess of any applicable General Overall, Limited Overall, and/or Annual Maximum Plan Benefits. Plan exclusions apply whether or not services are medically necessary.

NETWORK PREFERRED PROVIDER ORGANIZATION (PPO) SERVICES

If you receive medical services or supplies from a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO) you will be responsible for paying less money out of your pocket.

In Arizona, Preferred Health Care Providers are members of the Blue Cross Blue Shield Arizona PPO Network who have agreed to accept the amounts the Plan actually pays for covered services, plus any additional amounts you must pay (i.e. deductible, copay, coinsurance), as described in the Schedule of Medical Benefits or in the Medical Network chapter of this document.

ELIGIBLE MEDICAL EXPENSES <u>NOT</u> PAYABLE BY THE PLAN

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred a maximum Out-of-Pocket cost (applicable only to the Coinsurance), no further Coinsurance will be applied.

In addition, there is a General Overall Annual Maximum Plan Benefit applicable to each Plan Participant, as well as certain Limited Overall Maximum Plan Benefits and Annual Maximum Plan Benefits applicable to each Plan Participant with respect to certain Eligible Medical Expenses. These features are described in the following sections of this chapter, and any applicable Maximum Plan Benefit is shown in the relevant Schedule of Medical Benefits.

DEDUCTIBLES

The deductible is the amount you must pay each calendar year before the Plan pays benefits. The amount applied to the deductible is the lesser of billed charges or the amount considered to be Contracted or Allowed Charges under this Plan. In most cases, each year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible. Then, the Plan begins to pay benefits. Deductibles are accumulated on a **calendar** year basis. There are two main types of Deductibles: Individual and Family.

- The **Individual Deductible** is the maximum amount **one** covered person has to pay before Plan benefits begin. The Plan's Individual Deductible varies depending on the plan selected and the use of network or non–network providers.
- The **Family Deductible** is the maximum amount that a family of **three** or more is responsible for paying before Plan Benefits begin. The Plan's Family Deductible also varies depending on the plan selected and the use of network or non-network providers.
- There is a separate retail prescription drug deductible outlined under Drugs in the Schedule of Medical Benefits.

Only eligible medical expenses can be used to satisfy the Plan's deductible. As a result, non-eligible medical expenses, do not apply to the deductible. Services paid with a copay are not subject to the deductible. Deductibles are applied to eligible medical expenses **in the order in which the claims are received by the Plan.**

- **Note that the Individual and Family In-Network and Out-of-Network deductibles are NOT interchangeable, meaning you may not use any portion of an In-Network deductible to meet an Out-of-Network deductible and vice versa**.

Expenses Not Subject to Deductibles: Certain Eligible Medical Expenses are not subject to Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copayments (explained below). See the Schedule of Medical Benefits chapter of this document to determine when Eligible Medical Expenses are not subject to Deductibles.

COINSURANCE

Once you've met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (**not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. Unless the Schedule of Medical Benefits indicates otherwise, this Plan generally pays a greater percentage of the Eligible Medical Expenses after the Deductible is satisfied, and you are responsible for the remaining lesser percentage.

Coinsurance When You Use Network Health Care Providers: <u>The plan pays a greater percentage of benefits when you use network providers for the Plan you selected.</u>

Coinsurance When You Don't Comply with Utilization Management Programs: If you fail to follow certain requirements within the Plan's Utilization Management Program, the Plan will pay a smaller percentage of the cost of those services, and you will have to pay a greater percentage of those costs. The amount you'll have to pay **will not** be subject to the Plan's Deductible. See also the Utilization Management chapter of this document.

COPAYMENT

A Copayment (or Copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan pays the balance. When Copayments apply, generally there are no Deductibles or Coinsurance unless the Plan specifically provides otherwise. The Plan's Copayments are indicated in the Schedule of Medical Benefits. Copayments will continue to be your responsibility even after your annual Out-of-Pocket maximum is reached. Copayments do not accumulate to meet the Plan's deductible.

OUT-OF-POCKET EXPENSES (also called Coinsurance Stop Loss)

Out-of-Pocket Explained:

Out-of-pocket costs are the in-network eligible expenses which must be paid by the plan participant **before** this Plan will pay in-network benefits at 100% of Allowed or Contracted Charges. Each calendar year, after an individual incurs a maximum Out-of-Pocket cost for eligible in-network services as described in the Schedule of Medical Benefits (not including the deductible) for any individual, no further coinsurance will apply to covered Eligible In-Network Medical Expenses for the rest of that calendar year for that individual. As a result, the Plan will pay 100% of coinsurance for all covered Eligible In-Network Medical Expenses that are incurred during the remainder of the Calendar Year after the Out-of-Pocket Maximum has been reached. **However, you will still be responsible for paying all of the expenses described in the section below.**

Expenses <u>Not</u> Subject to the Out-of-Pocket Maximum: You are always responsible for paying for certain expenses for medical services and supplies yourself. Under this Plan, each year, you will be responsible for paying the following expenses out of your own pocket:

1. Your Individual or Family Deductible.

2. Any applicable in-network Coinsurance up to the medical out-of-pocket maximum.
3. Any applicable Copayment (copay).
4. All expenses for medical services or supplies that are not covered by the Plan.
5. All charges in excess of the Allowed or Contracted Charge determined by the Plan.
6. All charges in excess of the Plan's General Overall, Limited Overall and/or Annual Maximum Benefits, or in excess of any other limitation of the Plan.
7. Coinsurance, copays or expenses associated with outpatient retail or mail order prescription drugs.
8. All expenses incurred because of failure to follow the Utilization Management provisions of this Plan.
9. Out-of-network expenses.

ANNUAL MAXIMUM PLAN BENEFITS

General Overall ("Annual") Maximum Plan Benefit: A General Overall ("Annual") Maximum Plan Benefit is the maximum amount of benefits payable by the Plan during the calendar year in which a Plan Participant is covered under any plan option offered under this Plan and any previous medical expense plan provided by the City of Mesa during that calendar year. The Plan will not pay any further Plan Benefits on account of a Covered Individual once the Plan has paid the General Overall Maximum Plan Benefit for that individual.

- The **General Overall ("Annual") Maximum Plan Benefit is $2,000,000 for you and $2,000,000 for each of your covered Dependents** payable for all medical expenses (except for medical expenses that are shown in the Schedule of Medical Benefits to be subject to a lower Limited or Annual Maximum Plan Benefits).
- This **does not** mean, nor should it be construed to mean, that the Plan has any obligation to pay any Benefits during the calendar year for the Plan Participant **after** coverage terminates.

Limited Overall ("Annual") Maximum Plan Benefits: Plan Benefits for certain medical expenses are subject to Limited Overall ("Annual") Maximums for each Covered Individual. Once the Plan has paid the Limited Overall Maximum Plan Benefits for any of those services or supplies on behalf of any Covered Individual, it will not pay any further Plan Benefits for those services or supplies on account of that individual, even though the General Overall Maximum Plan Benefit has not been reached. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of the Limited Overall Maximum Plan Benefits are identified in the Schedule of Medical Benefits. This **does not** mean, nor should it be construed to mean, that the Plan has any obligation to pay any Benefits during the calendar year for the Plan Participant after coverage terminates.

Specific Annual Maximum Plan Benefits: Plan Benefits for certain medical expenses are subject to Annual Maximums per Covered Individual or family during each calendar Year. Once the Plan has paid the Annual Maximum Plan Benefits on behalf of any Covered Individual or family, it will not pay any further Plan Benefits for those services or supplies on account of that individual or family for the balance of the calendar Year, regardless of whether the Plan has paid the General Overall Maximum Plan Benefit for that individual. The services or supplies that are subject to Annual Maximum Plan Benefits are identified in the Schedule of Medical Benefits.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage (for each of the plan options outlined in this document) is "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (October 15th through December 7th of each year).

This Plan **does not coordinate benefits with Medicare Part** D. If you enroll in Medicare Part D prescription drug plan you may not enroll in or keep prescription drug coverage under this Plan. You will be disenrolled from the prescription drug coverage under this Plan as long as you are enrolled in a Medicare Part D prescription drug plan.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from the Employee Benefits Administration Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

The Medicare program has arranged to let employer-sponsored Plans, who have applied for a subsidy, know if their participants have tried to enroll in a Medicare Prescription Drug Plan. This is because many people with Medicare may not understand that they are able to keep their current employment based prescription drug coverage and do not need the Medicare

Part D prescription drug coverage. If we are advised that you have tried to enroll in a Medicare Prescription Drug Plan, we will contact you to see if that is your final decision or just an error.

SCHEDULE OF MEDICAL BENEFITS

A chart describing the Plan's medical benefits, with explanations and limitations of those benefits appears on the following pages. Each of the Plan's medical benefits is described in the first column, with Hospital Services (Inpatient) and Physician and Health Care Practitioner Services appearing first. These two categories cover most (but not all) health care services covered by the Plan. They are followed by descriptions of all other benefits for specific health care services and supplies that are listed in **alphabetical** order.

Explanations and limitations that apply to all Benefits are shown in the second column of the Schedule of Medical Benefits. Specific differences in the Benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use providers who are not contracted with the PPO) are shown in the subsequent columns.

Payment of out-of-network claims is according to the Allowed or Contracted Charge reimbursement as defined in this Plan.

The following Schedule of Medical Benefits outlines this Plan's Deductibles, Coinsurance, General Overall Maximum Plan Benefit and the Annual Out-of-Pocket Maximum.

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
General Overall ("Annual") Maximum Plan Benefit, also called the Plan Year Maximum • The plan year maximum is the most this Plan will pay for all covered expenses for one person who is enrolled in any Plan option.		$2,000,000 per person per calendar year							
Out-of-Pocket Maximum • Out-of-pocket costs are the in-network expenses you must pay **before** this Plan will pay benefits at 100% of Contracted Charges. After you pay the maximum annual Out-of-Pocket cost in coinsurance, no further coinsurance will apply to your eligible in-network medical expenses for the rest of that calendar year.	• These expenses do not accumulate to meet your annual out-of-pocket maximum: deductibles, copays, expenses not covered by the Plan, charges in excess of the Allowed or Contracted Charge, a Plan benefit maximum, a penalty for failure to follow UM procedures or expenses associated with outpatient retail or mail order prescription drugs, and out-of-network expenses.	Medical: $2,000 per person	Not applicable	Medical: $1,000 per person	Not applicable	Medical: $5,000 per person	Not applicable	Out-of-Pocket Maximum is not applicable because there is no coinsur-ance response-bility since benefits are paid at 100% after copays.	Not applicable
Deductible • The medical plan deductible is the amount of money you must pay each calendar year before the Plan pays benefits.	• Note that the In-Network and Out-of-Network deductibles are NOT interchangeable or commingled, meaning you may not use any portion of an In-Network deductible to meet an Out-of-Network deductible and vice versa.	$300 per person $900 per family	$1,000 per person $3,000 per family	$200 per person $600 per family	$1,000 per person $3,000 per family	$550 per person $1,650 per family	$1,000 per person $3,000 per family	None	$1,000 per person $3,000 per family

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Hospital Services (Inpatient) • Room & board in semiprivate room with general nursing services. Specialty care units (*e.g.*, intensive care, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (*e.g.*, prescriptions, supplies). • Newborn care; newborn circumcision. **Be sure to follow the Newborn Eligibility requirements of this plan to assure coverage for newborn children!**	• **Elective Hospitalization is subject to precertification**. **All Hospitalization is subject to concurrent review.** See the Utilization Management chapter for details. • Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. • Hospitalization for dental services **is not** payable under the medical benefits of this City. • Observations up to 72 hours, without admission, are covered under the emergency room copay/co-insurance. After 72 hours, the inpatient copay/coinsurance applies.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	$200 copay per admission then plan pays 100%	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Physician and Health Care Practitioner Services • Office, Hospital, emergency room, and other health care facility visits of Physicians and Health Care Practitioners. • Surgeon fees. • Assistant surgeon (if Medically Necessary). • Anesthesia fees for Physicians and Certified Registered Nurse Anesthetists (CRNA). • Audiology/Hearing Exams. • Certified Perfusionist for heart-lung surgical procedures. • Pathologist and Radiologist fees. • Physician Assistant, Nurse Practitioner and Nurse Midwife fees. • Retail Medical Clinics. • Psych and neuropsychiatric testing by a Physician or Psychologist. See also the Behavioral Health row of this Schedule.	• **Some surgical services are subject to precertification. For details, see the Utilization Management chapter.** • The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "**Surgery"** in the Definitions chapter. • **Assistant Surgeon fees** will be reimbursed for services to a **maximum** of 25% of the allowed or contracted expenses payable to the primary Surgeon. • See the Definition section for retail medical clinics. • The medical plans in this document do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider. You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	Office Visits: 100% after a $20 copay per visit All other services: 50% after deductible Prenatal visits are subject to the office visit copay. For prenatal visits you pay a maximum of 15 copays. Contact the Benefits Claims Admin-istrator for information about your specific prenatal claims.	25% after deductible	Office Visits: 100% after a $20 copay per visit All other services: 100% Prenatal visits are subject to the office visit copay. For prenatal visits you pay a maximum of 15 copays. Contact the Benefits Claims Admin-istrator for information about your specific prenatal claims.	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Allergy Services • Allergy sensitivity testing, including skin patch or Rast/Mast blood tests. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Covered only when ordered by a Physician. • No coverage for allergy services considered to be experimental by the Plan, such as sublingual allergy treatment. See Allergy in the Exclusion chapter.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	Physician services: 100% after a $20 copay per visit Allergy shots when no physician visit: 100% after a $5 copay Allergy antigen: 100% no copay	60% after deductible
Alternative Health Care Services • Acupuncture services. • Office visit with a Homeopathy or Naturopathy provider.	• Services are covered only if the Plan Administrator or its designee determines that the practitioner is licensed or duly authorized to practice in the jurisdiction in which the services and supplies are provided • General office visits with an acupuncturist are not covered Homeopathic and Naturopathic supplies, medication and treatments are **not** covered.	80% after deductible to a max of $1,000 per person per calendar year (in or out-of-network)	Covered as In-network benefit	90% after deductible	Covered as In-network benefit	Not covered	Not covered	Not covered	Not covered
Ambulance	• See the Emergency services row in this schedule.								
Ambulatory Surgery Facility	• See the Specialized Health Care Facility row in this schedule.								

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Behavioral Health Services **(EAP, Mental Health, Substance Abuse Treatment)** **Employee Assistance Program (EAP):** • See page 70 **Mental Health and Substance Abuse:** • **Outpatient Visits:** Intensive outpatient, day treatment and partial day care. • **In-Patient Admission:** Hospital and residential treatment center services.	• Coverage for both outpatient and inpatient behavioral health services is available through the medical plan elected by the participant. • Neuropsychological testing for medical conditions is covered under the medical plan. • Behavioral health hospitalization, day treatment, partial day care, intensive outpatient and residential treatment center services **are subject to precertification**. See the Utilization Management chapter for details. • See the specific exclusions related to Behavioral Health Services, including mental retardation and learning disability, in the Exclusions chapter. Benefits are payable only for services of Behavioral Health Care Providers listed in the Definitions chapter. • **For payment of Outpatient Prescription drugs ordered by Behavioral Health Providers** refer to the Drug section of this Schedule of Medical Benefits.	Outpatient and Inpatient Services: 80% after deductible	Outpatient and Inpatient Services: 60% after deductible	Outpatient and Inpatient Services: 90% after deductible	Outpatient and Inpatient Services: 70% after deductible	Outpatient: 100% after a $20 copay per visit Inpatient Services: 50% after deductible All other outpatient services: 50% after deductible	Outpatient and Inpatient Services: 25% after deductible	Outpatient including Intensive outpatient, day treatment and partial day care 100% after a $20 copay per visit Inpatient: $200 copay per admission then plan pays 100%	Outpatient and Inpatient Services: 60% after deductible
Birthing Center	• See the Specialized Health Care Facility row in this schedule.								
Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician. • Autologous (patient's own) blood transfusion expenses are not payable under this plan.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Specialized Health Care Facility, Physician's office or at home	• See also the exclusion of Hair Replacement Procedures in the Exclusion chapter. • A single wig or toupee is payable to a maximum of $500 once in a lifetime if it is required to replace hair lost as a result of chemotherapy.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	Chemo-therapy: 100% after a $20 copay per date of chemo-therapy treatment. If Chemo-therapy treatment is reported with an office visit on the same date of service no copay applies to the chemo-therapy charges. Wig: 100% after a $20 copay.	60% after deductible
Chiropractic Services	• See Spinal Manipulation in this table.								

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Corrective Appliances (Prosthetic & Orthotic Devices, Other Than Dental) • Coverage is provided for rental (but only up to the Allowed or Contracted purchase price of the device); purchase of standard model at option of the Plan; medically necessary repair, adjustment or servicing of the device; and replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Colostomy or ostomy supplies. • Hearing aids and devices. Hearing aids, batteries and hearing aid repairs are payable to a maximum of $500 per person per calendar year. Audiology exams are payable under the Physician and Health Care Practitioner Services of this plan. • Foot Orthotics are payable to a maximum of $500 per person per calendar year. Services must be rendered by a network provider. • See also the Vision section of this Schedule of Medical Benefits regarding coverage for eyeglasses following certain types of eye surgery. • A wig is payable to a maximum of $500/person/lifetime. • An external silicone breast prosthesis is payable as medically necessary once every 24 months. A fabric, foam, or fiber-filled breast prosthesis is payable as medically necessary once every 6 months. • Up to four post-mastectomy bras are payable as medically necessary every 12 months.	• See the specific exclusions related to Corrective Appliances in the Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter. • Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner. • Occupational therapy (orthotic) supplies needed to assist the person in performing activities of daily living are **not** covered. • Implantable hearing devices such as cochlear implant are payable for participants who meet all of the following criteria: a) the participant has been covered under one of the City's medical plan options for a minimum of two years; b) the procedure is determined to be medically necessary by the City's Utilization Review firm; c) only in-network health providers are utilized for the surgical procedure and follow-up care. • The Plan will pay a maximum of $20,000 per person per lifetime toward all expenses/supplies and equipment related to the implantable hearing device. There is a $2,000 deductible for this benefit in addition to any other required deductible of the plan in which the participant is enrolled. Complications related to an implantable hearing device are payable and not included in the $20,000 lifetime maximum.	80% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year.	60% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year. No coverage for foot orthotics out of network.	90% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year.	70% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year. No coverage for foot orthotics out of network.	50% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year.	25% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year. No coverage for foot orthotics out of network.	100% after a $20 copay. An additional copay applies to supplies added to corrective appliances. Hearing aid: 100%$500 max payable per person per calendar year.	60% after deductible Hearing aid: 100% no deductible $500 max payable per person per calendar year. No coverage for foot orthotics out of network.

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Dialysis • Hemodialysis or peritoneal dialysis and supplies.	• Covered only when ordered by a Physician and administered under the direction of a Physician in a Hospital, Specialized Health Care Facility, Physician's office or at home.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% after a $20 copay per visit	60% after deductible

Disease Management Services
• Benefits are available for educational programs for patients or parent(s) of eligible dependent children teaching the care and management of chronic diseases (such as diabetes, asthma, etc.), designed to improve the patient's knowledge of the disease, techniques for self-management and compliance with proper health care procedures required for the patient's well-being.
• These Disease Management services are subject to the conditions and the Limited Overall Maximum Plan Benefit shown to the right.
• Disease Management Programs are covered only when ordered by a Physician; **and pre-approved** by the Plan Administrator or its designee.
• The Disease Management benefit may be used to cover expenses incurred by a nutritionist when required for Weight Loss Surgery or with a diagnosis of Obesity or Morbid Obesity.
	• **Deductible and Coinsurance do not apply to these benefits.**
	• **The Limited Overall Maximum Plan Benefit for a Disease Management Program is $500 per disease per lifetime, in or out-of-network.** Plan coverage is in the form of reimbursement for expenses used, to the maximum allowable under this benefit. The Plan Participant must submit a receipt showing the:
	  • cost of the program; and
	  • name, address and telephone number of the program sponsor; and
	  • dates and times classes were held; and
	  • proof of classes actually attended by the participant.
	• If the Plan Participant attended 80% or more of the scheduled classes, full reimbursement of the cost of the program will be made, subject to the applicable Limited Overall Maximum Plan Benefit. If the Plan Participant attended less than 80% of the scheduled classes, no reimbursement will be paid.
		100%, no deductible
		Services MUST be pre-approved by the Plan Adminis-trator or designee.
			100%, no deductible
			Services MUST be pre-approved by the Plan Adminis-trator or designee.
				100%, no deductible
				Services MUST be pre-approved by the Plan Adminis-trator or designee.
					100%, no deductible
					Services MUST be pre-approved by the Plan Adminis-trator or designee.
						100%, no deductible
						Services MUST be pre-approved by the Plan Adminis-trator or designee.
							100%, no deductible
							Services MUST be pre-approved by the Plan Adminis-trator or designee.
								100%
								Services MUST be pre-approved by the Plan Adminis-trator or designee.
									100%, no deductible
									Services MUST be pre-approved by the Plan Adminis-trator or designee.

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Drugs and Medicines • Coverage is provided only for those pharmaceuticals approved by the US Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them. • The following classes of drugs are each payable to a **maximum of $500 per person per calendar year:** anti-obesity/weight loss drugs, prescription vitamins, drugs to treat erectile dysfunction (impotency) for males age 18 and over (payable to the lesser of 8 units or 30 days per prescription), tretinoin products (e.g. Retin-A). • Fertility drugs are only payable if prescribed for non-fertility therapy. • **These are some of the classes of drugs payable by the Plan:** Prenatal vitamins requiring a prescription; diabetic supplies including insulin, syringes, blood glucose monitors, lancets, alcohol swabs, test strips & test tape, emergency contraceptives (2 kits/30 days). • **Certain drugs require prior authorization by calling the Prescription Drug Program, such as:** Gleevac, Cox II inhibitors like Celebrex, Retin-A after age 35, migraine medications, weight reduction medications, self-injectable medications like Betaseron, growth hormone, interferon, multiple sclerosis drugs, etc. • Drugs not yet approved by the FDA are not covered**.** New FDA-approved drugs will be covered by the Plan unless an amendment states otherwise or the class of drug is excluded.	• Benefits for prescription drugs are available through the Plan's prescription drug network. For locations of the network pharmacies, or information on the formulary drugs contact the Prescription Drug Program at their phone number/website listed on the Quick Reference Chart in the front of this document. • **Retail Network (PPO) pharmacy:** To obtain up to a 30-day supply of medication for the fees noted to the right, present your ID card to any in-network participating retail pharmacy. For the location of in-network retail pharmacies contact the Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this document. Prescription drug prices will be discounted to you. • **Home Delivery (Mail Order) Services:** You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. To use mail order have the doctor write a prescription for a 90-day supply, with refills. Mail prescription, copay and mail order form to the Mail Order service of the Prescription Drug Program. Obtain mail order forms from the Prescription Drug Program. Allow up to 14 days for your order. • See the drug exclusions in the Exclusions chapter. No coverage for over-the-counter (OTC) drugs, drugs to treat infertility, certain dental drugs, non-prescription contraceptives. • **For all plan options if you fill a drug with a brand name when a generic drug is available, you pay the difference in price between the brand and generic drug plus the applicable copay or coinsurance. Also, after the 3rd refill of a maintenance drug filled at retail, the mail order must be used or else the retail copay is doubled & coinsurance increases another 5%.** • NOTE: Coinsurance, copays or expenses associated with outpatient prescription drugs do not accumulate to the medical plan deductible or out of pocket maximum.	Refills for maintenance medication at a Retail pharmacy are permitted until the 3rd refill, thereafter the medication should be filled via Mail Order Home Delivery or else a penalty applies where instead of the normal retail benefit you pay more money as outlined below under "Retail Pharmacy: Maintenance." **Retail Pharmacy:** for acute or short-term medications and up to 3 fills of maintenance medication (up to a 30-day supply) **Retail Prescription Drug Deductible:** **$50 per person per calendar year** *Generic drugs*: The greater of a $5.00 copay or 20% to a max of $50 *Formulary Brand drugs*: The greater of a $25.00 copay or 25% to a max of $100 *Non-Formulary Brand drugs*: The greater of a $35.00 copay or 40%, to a max of $100 **Retail Pharmacy: Maintenance or Long-Term Use Medication after the 3rd fill at a Retail Pharmacy:** (up to a 30-day supply) *Generic drugs:* The greater of a $10.00 copay or 25% to a max of $100 *Formulary Brand drugs*: The greater of a $50.00 copay or 30% to a max of $200 *Non-Formulary Brand drugs:* The greater of a $80.00 copay or 45%, to a max of $200 **Mail Order:** (up to a 90-day supply) *Generic drugs:* The greater of a $10.00 copay or 20% to a max of $100 *Formulary Brand drugs:* The greater of a $50.00 copay or 25% to a max of $200 *Non-Formulary Brand drugs*: The greater of a $80.00 copay or 40% to a max of $200 **Non-Network (Non-PPO) Retail Pharmacy**: There is no discount. If you fill a prescription at an out-of-network non-participating pharmacy location, you will need to pay for the drug at the time of purchase and later send your drug receipt and claim form to the Prescription Drug Program (at their address on the Quick Reference Chart). You will be reimbursed based upon the amount that would have been charged by a participating pharmacy, less the applicable retail coinsurance. Claim forms are available at the website of the Prescription Drug Program or the Employee Benefits office.	**Outpatient prescription drug deductible** is $250 per person per year (retail and mail combined). Once the deductible is met then prescription drugs are payable as follows: **Retail:** (up to a 30-day supply) **Generic drugs**: The greater of a $5.00 copay or 20%, to a max of $50. **Formulary Brand drugs**: The greater of a $25.00 copay or 25%, to a max of $100. **Non-Formulary Brand drugs**: The greater of a $35.00 copay or 40%, to a max of $200. **Mail Order:** (up to a 90-day supply) **Generic drugs**: The greater of a $10.00 copay or 20% to a max of $100. **Formulary Brand drugs**: The greater of a $50.00 copay or 25% to a max of $200. **Non-Formulary Brand drugs**: The greater of a $80.00 copay or 40% to a max of $300.	Drugs are payable like the **non-network retail pharmacy provisions** as noted in the column to the left under the Choice PPO, Choice Plus PPO plans	No deductible applies. **Retail:** (up to a 30-day supply) **Generic:** $15 copay **Formulary Brand:** $35 copay Non-**Formulary Brand:** $65 copay **Mail Order**: (up to a 90-day supply) **Generic:** $30 copay **Formulary Brand**: $70 copay **Non-Formulary Brand:** $130 copay	Drugs are payable like the **non-network retail pharmacy provisions** as noted in the column to the left under the Choice PPO, Choice Plus PPO plans.

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Durable Medical Equipment (DME) **(including Oxygen)** Coverage is provided for: • Rental (but only up to the allowed or contracted purchase price of the Durable Medical Equipment); • Purchase of standard models at the option of the Plan; • Medically Necessary repair, adjustment or servicing of the Durable Medical Equipment; • Medically Necessary replacement of the Durable Medical Equipment due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired.	• **Precertification required for all DME with a cost of over $1,000.** • See the specific exclusions related to Durable Medical Equipment in the Exclusions chapter. • To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. • Durable Medical Equipment is covered only when its use is Medically Necessary, it is ordered by a Physician or Health Care Practitioner and it is purchased through a Durable Medical Equipment provider or supplier. Items purchased through the Internet are not covered. • Coverage is provided for Medically Necessary Oxygen, along with the Medically Necessary equipment and supplies required for its administration.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% after a $20 copay per piece of equipment purchased or per month for rental. Necessary supplies purchased at the same time as the covered DME are payable at 100%, no copay.	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Emergency Services • Hospital **Emergency Room** facility for a medical emergency. • **Ambulance**: Ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of medical emergency, acute illness or inter health care facility transfer. Air transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient. • **Urgent Care** facility.	• Expenses for use of Hospital emergency room and/or Ambulance are covered only when services are for Emergency Services. Observations up to 72 hours, without admission, are covered under the emergency room copay/co-insurance. After 72 hours, if admitted then the inpatient copay/coinsurance will apply. • See the definition of "Emergency Services" in the Definitions chapter. • The Utilization Management Company must be notified of an emergency hospital admission within 48 hours of that admission. See the Utilization Management chapter for details.	ER and Urgent Care: 80% after deductible Ambulance: 80% after deductible	ER: 80% after deductible Urgent Care: 60% after deductible Ambulance: 80% after deductible	ER and Urgent Care: 90% after deductible Ambulance: 90% after deductible	ER: 90% after deductible Urgent Care: 70% after deductible Ambulance: 90% after deductible	ER and Urgent Care: 50% after deductible Ambulance: 50% after deductible	ER: 50% after deductible Urgent Care: 25% after deductible Ambulance: 50% after deductible	ER: 100% after a $100 copay per visit. Copay waived if admitted but inpatient copay applies Inpatient: $200 copay Ambulance: 100%, no copay Urgent Care: 100% after a $50 copay per visit Observation up to 72 hours are covered 100%	ER: 100% after a $100 copay per visit. Copay waived if admitted but inpatient copay applies Inpatient: $200 copay Ambulance: 100% after deductible Urgent Care: 60% after deductible
Endoscopy Services (outpatient) • Technical and professional fees associated with endoscopic procedures performed as an outpatient such as colonoscopy, gastroscopy, bronchoscopy.	• **Endoscopy Services require precertification.** • Covered only when medically necessary and ordered by a Physician or Health Care Practitioner. • See also the Preventive benefit described in this Schedule of Medical Benefits for coverage of a screening colonoscopy.	80% after deductible for facility	60% after deductible for facility	90% after deductible for facility	70% after deductible for facility	50% after deductible for facility	25% after deductible for facility	$100 copay 100% for facility	60% after deductible for facility

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Fertility, Genetic, Reproductive, Family Planning and Sexual Dysfunction Services • Prescription contraceptives (such as diaphragm, intrauterine devices) and voluntary surgical sterilization (*e.g.*, vasectomy, tubal ligation, Essure). Note certain prescriptions such as birth control pills are payable under the Drug section of this Schedule of Medical Benefits. • Fertility and infertility services include evaluation and diagnostic lab services related to hormonal evaluation and associated infectious disease for the member and spouse. • **Adoption**: For employees and retirees who are enrolled in one of the City's medical plans, a one-time benefit of $2,000 per child will be paid toward adoption expenses, once proof of final adoption has been presented to the Employee Benefits Administration Office. Natural children of either parent who are adopted by the non-natural parent are not eligible for this benefit. When both parents are employees of the City, only one employee per family may receive this adoption benefit.	• **Genetic Testing Services requires Precertification procedure.** • See the specific exclusions related to Fertility, Genetic, Reproductive and Sexual Dysfunction Services in the Exclusions chapter. • Prescription contraceptives for birth control are payable including but not limited to: birth control drugs and devices, injectables (*e.g.*, Depo-Provera), intrauterine devices (IUD), diaphragms, emergency contraception, and implantable birth control devices and services (*e.g.*, Norplant). Prescription contraceptive medications payable under the Drug section of this Schedule. **Reproductive/Preventive Drugs and devices are payable to a maximum of $500/calendar year.** • No coverage for the surgical treatment of sexual dysfunction. See the Drug row of this schedule for more information. • No coverage for fertility/infertility treatment. • No coverage for genetic services, tests and/or procedures except when performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women and high-risk individuals. See preventive services section re: BRCA testing and counseling	**Voluntary Sterili-zation services**: 50% after deductible **Fertility diagnosis**: Not covered **Prescription contra-ceptive services:** 80% to the benefit maximum	**Voluntary Sterili-zation services:** Not covered **Fertility diagnosis**: Not covered **Prescription contra-ceptive services**: 60% to the benefit maximum	**Voluntary Sterili-zation services**: 50% after deductible **Fertility diagnosis**: 90% after deductible to a maximum of $5,000 per person per lifetime, in or out of network **Prescrip-tion contra-ceptive services:** 90% to the benefit maximum	**Voluntary Sterilization services:** Not covered **Fertility diagnosis**: 70% after deductible to a maximum of $5,000 per person per lifetime, in or out of network **Prescription contra-ceptive services:** 70% to the benefit maximum	**Voluntary Sterilization services**: 50% after deductible **Fertility diagnosis**: Not covered **Prescription contra-ceptive services:** 50% to the benefit maximum	**Voluntary Sterilization services:** Not covered **Fertility diagnosis**: Not covered **Prescription contra-ceptive services:** 25% to the benefit maximum	**Voluntary Sterilization services**: 50% no deductible **Fertility diagnosis**: Not covered **Prescrip-tion contra-ceptive services:** $20 copay, then 100% to the benefit maximum	**Voluntary Sterili-zation services:** Not covered **Fertility diagnosis**: Not covered **Prescription contra-ceptive services**: 60% to the benefit maximum

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Home Health Care and Home Infusion Services • Part-time, intermittent **Skilled Nursing Care** services and medically necessary supplies to provide Home Health Care or home infusion services. • **Home services other than Skilled Nursing Care are not covered.**	• **Home Health and Home Infusion Therapy Services require precertification.** See the Utilization Management chapter of this document. • **Home health and Home Infusion Therapy Services are payable to a maximum of 60 visits per person per calendar year.** • See the exclusions related to Home Health Care and Custodial Care (including personal care and childcare) in the Exclusions chapter of this document. • Covered only when ordered by a Physician. • Home Hospice is payable as described below under Hospice benefits. Home Physical Therapy is payable as described below under Rehabilitation Services benefits. Outpatient prescription drugs are payable as described above under Drug and Medicine benefits.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% after a $20 copay per day	60% after deductible
Hospice • Length of coverage is based on medical necessity. • Applies to facility or home hospice care.	• **Hospice Services require precertification.**	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible
Laboratory Services (Outpatient) • Technical and professional fees. • See Hospital Services section of this schedule for inpatient laboratory services.	• Covered only when ordered by a Physician or Health Care Practitioner.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% no deductible	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Maternity Services • Hospital, Birthing Center, Physician and Nurse Midwife fees for Medically Necessary maternity services. • It is recommended, but not required, that pregnant women notify the Utilization Management Company as soon as possible once they know they are pregnant. • See also adoption under the Fertility benefits discussed in this table. • **IMPORTANT**: For a newborn to be covered by this Plan, you must follow the Newborn Eligibility requirements in the Eligibility chapter of this document. • **Charges for the baby and mother are billed separately to the Plan.**	• See the exclusions on Fertility and Reproductive Care in the Exclusions chapter. • Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). **Hospital stays in excess of those days stated above must be precertified**. • Expenses for elective induced abortion unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion..	80% after deductible	60% after deductible	90% after deductible	70% after deductible	See the Hospital and Physician services row of this Schedule Prenatal visits are subject to the office visit copay. For prenatal visits you pay a maximum of 15 copays. Contact the Benefits Claims Admin-istrator for information about your specific prenatal claims.	25% after deductible	See Hospital and Physician services row of this Schedule. Inpatient copay will be assessed to the mother and newborn. Prenatal visits are subject to the office visit copay. For prenatal visits you pay a maximum of 15 copays. Contact Benefits Claims Admin-istrator for info about your specific prenatal claims.	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Nondurable Supplies Coverage is provided for the following items as determined by the Plan Administrator or its designee: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. • Diabetic Supplies available through the Drug benefit noted earlier in this table	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% no deductible	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers

Oral and Craniofacial Services
• **Treatment of Accidental Injuries to the Teeth:** This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:
  • The accidental injury must have been caused by an extrinsic (external) force and not an intrinsic force (such as the force of chewing or biting); and
  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
  • The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions chapter.
• Oral and Craniofacial Surgery.
	• See the exclusions related to Dental Services in the Exclusions chapter.
	• **No coverage for procedures, services or supplies related to TMJ syndrome/dysfunction** (as defined in the Definitions chapter)**.** Medically necessary treatment of temporomandibular joint problems is payable, such as for arthritis or fracture are covered. See the definition of TMJ syndrome in the Definitions chapter of this document.
	• **Oral, maxillofacial or craniofacial surgery is limited** to cutting procedures for medically necessary procedures to remove tumors or cysts, treat abscesses or acute injury of the gum, cheek, lip, tongue, hard or soft palate or, medically necessary due to arthritic deterioration.
	• No coverage under this medical plan for treatment/removal of impacted teeth, root canal, gingivectomy, or dental abscess.
	• Orthognathic procedures are not payable unless determined by the Plan to be medically necessary.
		80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	See the Hospital and Physician services row of this Schedule	60% after deductible

Outpatient Surgery Facility	• See the Specialized Health Care Facility row in this schedule.								

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative services, including radiation therapy.	• Covered only when medically necessary and ordered by a Physician or Health Care Practitioner. • See also the Preventive Care Program for Women mammogram benefit described in this Schedule of Medical Benefits. • See Hospital Services section of this table for inpatient radiology services.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% no deductible	60% after deductible

Reconstructive Services and Breast Reconstruction after Mastectomy
• Includes expenses for Reconstructive Surgery, procedures or treatment intended to correct a deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or prior covered therapeutic procedure.
• Breast reconstruction as described to the right.
	• See the specific exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter.
	• Most Cosmetic and Dental services are excluded from coverage.
	• For any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:
	  • Reconstruction of the breast on which the mastectomy was performed;
	  • Surgery to produce a symmetrical appearance; and
	  • Prosthesis and physical complications for all stages of mastectomy, including lymphedemas.
		80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	Office Visits: 100% after a $20 copay per visit
								Hospital: $200 copay per admission then plan pays 100%
									60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Rehabilitation Services (Physical, Occupational, and Speech Therapy) • Short-term, **active, progressive** Rehabilitation Services (Occupational, Physical, Music or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • **Inpatient Rehabilitation Services** in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility are payable for short-term, **active, progressive** Rehabilitation Services that **cannot** be provided in an outpatient or home setting. • **Cardiac Rehabilitation** for those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.), when ordered by a Physician. • **Chiropractic modalities that are not spinal manipulation services.** • Rehab services covered only when ordered by a Physician. • Pulmonary rehabilitation is covered.	• **Inpatient Rehabilitation admission requires precertification.** See the Utilization Management chapter. • Maintenance Rehabilitation and coma stimulation services are **not** covered. See exclusions relating to Rehabilitation Therapies in the Exclusions chapter. • **Speech therapy:** Initial Precertification is required for speech therapy. Once speech therapy has been certified as Medically Necessary no further certification is required. See the Utilization Management chapter for details. Speech therapy is covered if directly associated with a medical illness or injury and the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy ordered for a person who has not yet learned to speak or to speak properly, is payable **only if pre-approved** by the Plan Administrator. Speech therapy for functional purposes, including but not limited to stuttering, stammering and conditions of psychoneurotic origin, is excluded, except as secondary to a specific medical condition.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	Outpatient Therapy: 100% after a $20 copay per therapy visit Inpatient rehabilitation admission: 100%, no deductible	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Second and Third Opinions • Includes only **one** Office Visit per opinion	• See the chapter on Utilization Management for details of the Second and Third Opinion Program and when the Plan may require a second or third opinion. • Additional Medically Necessary tests are covered under other Plan provisions.	Plan-required opinions: 100% after deductible Patient-requested opinion: 80% after deductible	Plan-required opinions: 100% after deductible Patient-requested opinion: 60% after deductible	Plan-required opinions: 100% after deductible Patient-requested opinion: 90% after deductible	Plan-required opinions: 100% after deductible Patient-requested opinion: 70% after deductible	Plan-required opinions: 100% after deductible Patient-requested opinion: 50% after deductible	Plan-required opinions: 100% after deductible Patient-requested opinion: 25% after deductible	Plan-required opinions: 100% after deductible Patient-requested opinion: no deductible 100% after $20 copay	Plan-required opinions: 100% after deductible Patient-requested opinion: 60% after deductible
Skilled Nursing Facility	• See the Specialized Health Care Facility row in this schedule.								

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Specialized Health Care Facilities • Ambulatory Surgical Facility/Center (Outpatient Surgery). • Birthing Center. • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) facility.	• **Admission to a Specialized Health Care Facility requires precertification**. See the chapter on Utilization Management for details. • Specialized Health Care Facility services must be ordered by a Physician. To determine if a facility is a "Specialized Health Care Facility," see the Definitions chapter of this Document. • **Birthing Center:** Benefits will not be more than those that would have been paid had the charges been incurred in the conventional labor, delivery or recovery rooms of the hospital which maintains the birthing center. • Benefits for the use of a **Skilled Nursing Facility** or **Subacute Care Facility** or any combination of either type of confinement is payable up to 60 days per calendar year.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	Outpatient Surgery Copay: $100 per admission then 100% All other Specialized Health Care Facilities: 100%, no copay	60% after deductible
Spinal Manipulation Services • Spinal Manipulation Services from a Physician (MD or DO) or Chiropractor.	• Maximum Plan Benefit for all **Spinal Manipulation services** is **25 visits** per individual per calendar year.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% after a $20 copay per visit	60% after deductible
Subacute Care Facility	• See the Specialized Health Care Facility row in this schedule.								

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Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Transplantation (Organ and Tissue) • Coverage is provided only for eligible services directly related to **Transplantation of human organs or tissue** to include: bone marrow, cornea, heart, kidney, liver, or lung(s), pancreas including facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • **Donor related transplant expenses** are payable to a maximum of $15,000 per transplant, payable over a 12-month period beginning on the date of the procedure. When donor expenses are payable by the donor's own health plan, this plan reserves the right to coordinate benefits as outlined in the COB chapter of this document.	• See the specific exclusions related to Experimental and Investigational Services and Transplantation in the Exclusions chapter. • **Transplantation services are subject to precertification**. See the chapter on Utilization Management for details. • Benefits are payable **only if** services are provided in a Hospital or Specialized Health Care Facility approved by the Plan Administrator or its designee. • **No coverage for travel and lodging expenses should you seek a transplant at a facility not located near your home.**	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	Inpatient Admission and Outpatient Surgical Facility copays will apply, then 100%, no deductible	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Vision (Eye Care) Services • Eyeglasses or corrective lenses only as described to the right.	• The cost of the first pair of eyeglasses or corrective lenses required after surgery to remove the lens of the eye is covered under this medical plan. • Eyeglasses or contact lenses are covered for certain other eye conditions such as keratoconus. Contact the Plan Administrator for information. • No coverage for the eye refraction or routine vision care associated with this benefit. • See also the separate Vision Care Plan described in this document.	80% after deductible	60% after deductible	90% after deductible	70% after deductible	50% after deductible	25% after deductible	100% after a $20 copay per visit	60% after deductible
Audiology/Hearing Services • Audiology/hearing exams • Hearing aids and devices.	• For payment of hearing exams, see the Physician and Health Care Practitioner Services row. • Hearing aids, batteries and hearing aid repairs are covered under the Corrective Appliances benefit in this plan.								

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Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Weight Management Services • Expenses for the surgical treatment of obesity (bariatric surgery) are payable including, but not limited to, gastric restrictive procedures (e.g. lap band) and intestinal bypass for adult participants who meet the criteria for Bariatric Surgery as noted to the right. • **Services must be precertified** by contacting the Utilization Management Company and performed by an in-network provider/facility and meet the criteria noted to the right.	**Criteria for Bariatric Surgery:** Requested Clinical Documentation includes complete History & Physical, in addition to specific medical documentation as follows: 1. Bariatric surgical consultation documenting the patient's current BMI (body mass index) 40 or greater, should the patient have a BMI of 35 – 39.9, the patient must have documentation of severe (severe as defined by comorbidities presenting a life-threatening situation that medical management alone would not be sufficient) weight-related illnesses that can be successfully alleviated with surgically assisted weight loss; and 2. Bariatric surgical consultation documenting that the patient does not have untreated or undertreated endocrinopathy that may be contributing factors to the individual's morbid obesity; and 3. Bariatric surgeon must have a defined pre-operative and post-operative weight management program to ensure the greatest outcome of the surgery and the patient; and 4. (6)-months physician supervised diet prior to surgery with nutritional consultations; and 5. Cardiac/Pulmonary Clearance; and 6. Basic Labs (within the last 6 months); and 7. Psychiatric Evaluation within the last 12 months recommending the approval of the bariatric surgery and the behavioral outcomes expected to warrant the performance of the surgery (covered under Behavioral Health benefit) While multiple surgical alternatives exist, the Plan may consider these bariatric surgical alternatives: Roux-en-Y (short or long limb), Vertical Banded Gastroplasty, Laparoscopic Gastric Banding, Duodenal Switch, and Biliopancreatic Diversion when considered medically necessary by the UM Company. See also the Drug row of this Schedule for coverage of weight loss prescription medication. **Note however that the Plan does not pay for post-weight loss skin reduction surgery/treatment.**	80% after deductible	No coverage	90% after deductible	No coverage	Office Visits: 100% after a $20 copay per visit All other services: 50% after deductible	No coverage	Office Visits: 100% after a $20 copay per visit All other services: 100% Hospital: $200 copay per admission then plan pays 100%	No coverage

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		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program–Children **(Covered Preventive Services for Children under the Federal Guidelines, PPACA)** • **Alcohol and Drug Use** assessments for adolescents age 11-21 years, annually • **Autism** screening for children at 18 and 24 months. • **Behavioral** assessments for children of all ages, 0-21 years, annually. • **Blood Pressure** screening for children 0-30 months, risk assessment every 2-3 months; 3 yrs – 21 yrs, annually. • **Cervical Dysplasia** screening for sexually active females, age 11 – 21 years (risk assessment). • **Congenital Hypothyroidism** screening one time for newborns. • **Depression** screening for adolescents at higher risk. • **Developmental** screening for children under age 3 (9, 18, and 30 months); surveillance throughout childhood (0-6; 12, 15, and 24 months; then annually to age 21 years. • **Dyslipidemia** screening. • **Fluoride Chemoprevention** supplements for children without fluoride in their water source. • **Gonorrhea** preventive medication for the eyes one time for newborns • **Hearing** screening one time for newborns.	• **Screening for congenital hypothyroidism: newborns -** The U.S. Preventive Services Task Force (USPSTF) recommends screening for congenital hypothyroidism (CH) in newborns. • **Screening for depression: adolescents** -The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. • **Dyslipidemia Screening:** Risk assessment at 2, 4, 6 & 8 years; age 10-17 years annually; at 20 years. • **Chemoprevention of dental caries:** The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. • **Prophylactic medication for gonorrhea: newborns -**The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO Plan		Choice Plus PPO Plan		Basic Choice PPO Plan		Copay Choice Plan	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program-Children **(Covered Preventive Services for Children under the Federal Guidelines, PPACA)** • **Height, Weight and Body Mass Index** measurements for children annually, age 2-21 years. • **Hematocrit or Hemoglobin** screening for children at 12 months. • **Hemoglobinopathies** or sickle cell screening one time for newborns • **HIV** screening for adolescents at higher risk. • **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/0-6yrs-schedule-pr.pdf; and http://www.cdc.gov/vaccines/recs/schedules/downloads/child/7-18yrs-schedule-pr.pdf • **Iron** supplements. • **Lead** screening at 12 & 24 months • **Medical History** for all children throughout development, annually up to age 21. • **Obesity** screening and counseling. • **Oral Health** risk assessment for young children.	• **Hematocrit or Hemoglobin:** Risk assessment at 4 months; 18 months; 24 months; and annually at 3 – 21 years • **Screening for HIV:** The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection. • **Iron supplementation in children -** The U.S. Preventive Services Task Force (USPSTF) recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. • **Screening and counseling for obesity: children -** The USPSTF recommends that clinicians screen children aged 6+ yrs for obesity and offer/refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. • **Quadrivalent HPV Vaccinations:** One time (3 doses) for age 9 – 18 years • **Lead screening:** Risk assessment at 6, 9, and 18 months; then annually, 3–6 years of age.	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage

Preventive Care Program-Children **(Covered Preventive Services for Children under the Federal Guidelines)** • **Phenylketonuria (PKU)** screening for this genetic disorder one time for newborns. • **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk. • **Smoking Cessation** for age 18-21 years. • **Tuberculin** testing for children at higher risk of tuberculosis. • **Vision** screening for all children • Well-baby and well-child visits, from birth to age 21.	• **Counseling for STIs: Risk assessment 11 – 21 years.** The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs. • **Smoking Cessation:** Maximum in each 365 day period: Nicotrol NS 90 days, Nicotrol Inhaler 90 days, Zyban 90 days, Chantix 180 days, Nicorette Gum/Lozenge 90 days, Nicotine Transdermal System 90 days. • **Tuberculin Test:** Risk assessment at 1, 6, 12, 18, and 24 months; and 3 – 21 years, annually. • **Screening for visual acuity in children:** The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage

<u>Preventive Care Program – Adults</u> **(Covered Preventive Services for men and/or women under the Federal Guidelines)** • **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked. • **Alcohol Misuse** screening and counseling. • **Aspirin** use for men and women of certain ages. • **Blood Pressure** screening for all adults annually	• **Screening for abdominal aortic aneurysm (AAA):** The U.S. Preventive Services Task Force (USPSTF) recommends one-time screening for AAA by ultrasonography in men aged 65 to 75 who have ever smoked. • **Screening and counseling to reduce alcohol misuse:** The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults 21+, including pregnant women in primary care settings. • **Aspirin to prevent CVD: men -** The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. Women 55 to 79. • **Screening for high blood pressure:** The USPSTF recommends screening for high blood pressure in adults aged 18 and older.	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage

<u>Preventive Care Program – Adults</u> **(Covered Preventive Services for men and/or women under the Federal Guidelines)** • **Cholesterol** screening for adults of certain ages or at higher risk. • **Colorectal Cancer** screening for adults over 50. • **Depression** screening for adults.	• **Screening for cholesterol abnormalities: men 35 and older -** The USPSTF strongly recommends screening men aged 35 and older for lipid disorders. • **Screening for cholesterol abnormalities: men under 35 -** The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. • **Screening for colorectal cancer:** The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years (once every 10 years). The risks and benefits of these screening methods vary. • **Screening for depression: adults -** The USPSTF recommends screening adults age 21+ for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage	100% covered	No Coverage

Preventive Care Program – Adults **(Covered Preventive Services for men and/or women under the Federal Guidelines)** • **Type 2 Diabetes** screening for adults with high blood pressure. • **Diet** counseling for adults at higher risk for chronic disease. • **HIV** screening for all adults at higher risk.	• **Screening for diabetes:** The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. • **Counseling for a healthy diet:** The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians • **Screening for HIV:** The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage
Preventive Care Program – Adults **(Covered Preventive Services for men and/or women under the Federal Guidelines)** • **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/adult-schedule.pdf • **Obesity sc**reening and counseling for all adults. • **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk.	• **Human Papillomavirus** (HPV): age 19 – 26 years, one time (3 doses) • **Screening and counseling for obesity: adults -** The USPSTF recommends that clinicians screen all adult patients age 21+ for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. • **Counseling for STIs:** The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs. • **Screening for syphilis: non-pregnant persons -** The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen persons at increased risk for syphilis infection.	100% Covered	No Coverage	100% covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage

Preventive Care Program – Adults **(Covered Preventive Services for men and/or women under the Federal Guidelines)** • **Syphilis** screening for all adults at higher risk. • **Tobacco Use** screening for all adults and cessation interventions for tobacco users.	• **Screening for syphilis: non-pregnant persons -** The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen persons at increased risk for syphilis infection • **Counseling for tobacco use:** The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. **Smoking Cessation:** Maximum in each 365 day period: Nicotrol NS 90 days, Nicotrol Inhaler 90 days, Zyban 90 days, Chantix 180 days, Nicorette Gum/Lozenge 90 days, Nicotine Transdermal System 90 days.	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage

Preventive Care Program – Women **(Covered Preventive Services for Women, Including Pregnant Women, under the Federal Guidelines)** • **Anemia** screening on a routine basis for pregnant women. • **Aspirin** use for men and women of certain ages. • **Bacteriuria** urinary tract or other infection screening for pregnant women. • **BRCA** counseling about genetic testing for women at higher risk. • **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40.	• **Screening for iron deficiency anemia:** The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women. • **Aspirin to prevent CVD: women -** The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. • **Screening for bacteriuria:** The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later. • **Counseling related to BRCA screening:** The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing (see Schedule of Medical Benefits for BRCA testing) • **Screening for breast cancer (mammography):** The USPSTF recommends screening mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage

Preventive Care Program – Women **(Covered Preventive Services for Women, Including Pregnant Women under the Federal Guidelines)** • **Breast Cancer Chemoprevention** counseling for women at higher risk. • **Breast Feeding** interventions to support and promote breast feeding. • **Cervical Cancer** screening for sexually active women. • **Chlamydia Infection** screening for younger women and other women at higher risk.	• **Chemoprevention of breast cancer:** The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention. • **Interventions to support breast feeding:** The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. • **Screening for cervical cancer:** The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix. • **Screening for chlamydial infection: non-pregnant women -** The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk. • **Screening for chlamydial infection: pregnant women -** The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage

Preventive Care Program – Women **(Covered Preventive Services for Women, Including Pregnant Women under the Federal Guidelines)** • **Cholesterol** screening for adults of certain ages or at higher risk. • **Folic Acid** supplements for women who may become pregnant. • **Gonorrhea** screening for all women at higher risk. • **Hepatitis B** screening for pregnant women at their first prenatal visit.	• **Screening for cholesterol abnormalities: women 45+.** • The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. • **Screening for cholesterol abnormalities: women under 45.** • The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease**.** • **Supplementation with folic acid:** The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. • **Screening for gonorrhea: women -** The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors. • **Screening for hepatitis B:** The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage

Preventive Care Program – Women **(Covered Preventive Services for Women, Including Pregnant Women under the Federal Guidelines)** • **Osteoporosis** screening for women over age 60 depending on risk factors. • **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk. • **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users. • **Syphilis** screening for all pregnant women or other women at increased risk.	• **Screening for osteoporosis:** The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage	100% Covered	No Coverage

MEDICAL PLAN EXCLUSIONS

The following is a list of medical services and supplies or expenses **not covered by any of the medical plan options.** The exclusions applicable to the Dental Plan appear in the Dental Plan Benefits chapter of this document. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

GENERAL EXCLUSIONS APPLICABLE TO ALL SERVICES AND SUPPLIES

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing forms and medical reports/medical records, bills, disability/sick leave/ or claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, mailing charges, prescription refill charges, disabled/handicapped plates/automotive forms/interest charges, late fees and mileage costs, provider administration fees, concierge/retainer agreement/membership fees or photocopying fees.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
4. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the City, or if benefits are otherwise provided under this Plan or any other plan that the City contributes to or otherwise sponsors.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation, Annual Maximum Plan Benefits, or Overall Maximum Plan Benefits as described in the Medical Expense Coverage chapter of this document.
6. **Expenses Exceeding Allowed or Contracted Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed or Contracted Charge as defined in the Definitions chapter of this document.
7. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Medical Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
8. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered.
9. **Expenses used to satisfy Plan Deductibles, copays** or expenses for a plan penalty for failure to comply with Utilization Management procedures.
10. **Expenses which are eligible for consideration under any other Plan of the employer**.
11. **Expenses arising from complications of any non-covered surgery, service or procedure (except for medical complications arising from an abortion).**
12. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
13. **Expenses related to complications of a non-covered service.**
14. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
15. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
16. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission or attempted commission of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice

of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. Upon receipt of notification of denial, the individual then has the right to appeal the denial of claims payment related to the injury or illness resulting from or sustained as a result of the alleged illegal act. Such appeal should be directed to the Plan Administrator who will submit it through the Appeal Process outlined in the Claims Information chapter of this plan document.

17. **Internet/Virtual Office/Telemedicine Services:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, web visit, physician-patient web service or physician-patient e-mail service, or telemedicine (real time or store and forward types) telehealth, e-health, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs, durable medical equipment or medical supplies obtained from an online internet provider.

18. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.

19. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.

20. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc., except as pre-approved by the Plan Administrator.

21. **No-Cost Services:** Expenses for services rendered or supplies provided for which a covered person is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

22. **No Physician Prescription:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Behavioral Health Practitioner, Nurse Midwife, Physician Assistant, Nurse Practitioner, Chiropractor, Acupuncturist, Homeopath, Naturopath, or Podiatrist.

23. **Non-Emergency Travel and Related Expenses**: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, covered person or family member of a covered person, unless those expenses have been pre-approved by the Plan Administrator.

24. **Occupational Illness/Injury or Third Party Expenses:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. Expenses for the treatment of conditions covered by workers' compensation or occupational disease law; or expenses for services or supplies for which another person, entity or third party may be liable for any payment. See the Coordination of Benefits Chapter for more information.

25. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the covered individual is confined to a Hospital or other Specialized Health Care Facility or to bed at home, guest meals, television, ~~VCR~~/DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

26. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations, functional capacity/job analysis examinations and testing required for employment, government or regulatory purposes, insurance, vocation, workers compensation, retirement/disability status or pension, or by any third party. Exception: Children requiring a school, camp, or sports exam may use the Well Child benefits described in the Schedule of Medical Benefits in this document. Also physical exams for the purpose of maintaining general health and wellness may be covered under the Preventive Services row in the Schedule of Medical Benefits.

27. **Private Room in a Hospital or Specialized Health Care Facility:** The use of a private room in a Hospital or other Specialized Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or designee.

28. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.

29. **Services Performed by Certain Health Care Practitioners:**
    - **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.
    - **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis, except as approved by the Plan Administrator.

30. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions chapter of this document or unexpected medical condition, or as pre-approved by the Plan Administrator.

31. **Surcharges:** any surcharge fees resulting from state laws (e.g. New York Health Care Reform Act).

32. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.

33. **Telephone Calls:** Any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation:
    - Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual;
    - Consultation with any Health Care Provider regarding medical management or care of a patient;
    - Coordinating medical management of a new or established patient;
    - Coordinating services of several different health professionals working on different aspects of a patient's care;
    - Discussing test results;
    - Initiating therapy or a plan of care that can be handled by telephone;
    - Providing advice to a new or established patient;
    - Providing counseling to anxious or distraught patients or family members;

34. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

35. **Allergy/Alternative/Complementary Health Care Services Exclusions**
    a. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
    b. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.
    c. Expenses for medications, natural remedies or treatments recommended or provided by a naturopath or homeopath, except office visits as payable under Alternative Health Care Services in the Schedule of Medical Benefits.
    d. Expenses for experimental/investigational allergy treatments including but not limited to sublingual (under the tongue) drops/oral antigen, rhinophototherapy (use of ultraviolet lights as a treatment for allergic rhinitis and other nasal conditions), repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).

36. **Behavioral Health Care Exclusions**
    a. Expenses for Behavioral Health Care services related to: adoption counseling; court-ordered Behavioral Health Care services; custody counseling; developmental disabilities; dyslexia; family planning counseling; learning disorders; marriage, couples, and/or sex counseling; mental retardation; pregnancy counseling; transsexual counseling; and vocational disabilities.
    b. Expenses for diagnosis, treatment, and prevention of Behavioral Health Disorders, including substance abuse, except as provided under Behavioral Health in the Schedule of Medical Benefits.
    c. Expenses for the following residential care services: residential treatment programs that are <u>not</u> solely for substance abuse treatment, residential schools for non-acute mental health care, wilderness programs, non-acute residential behavioral programs/admission, half-way house and group homes.
    d. Expenses for biofeedback or hypnosis/hypnotherapy.
    e. Expenses for Behavioral Health Care services related to:
        - dyslexia, learning disorders, educational delays, including tests and related expenses to determine the presence of or degree of a person's dyslexia or learning/reading disorder;
        - vocational disabilities;

- court-ordered Behavioral Health Care services or custody counseling (unless the services are determined by the Plan Administrator or its designee, to be medically necessary in the absence of a court order and such services are a covered benefit under the Plan);
- family planning/pregnancy/adoption counseling, transsexual/gender reassignment/sex counseling;
- marriage/couples counseling. Note: marital/family counseling is available through the EAP services discussed under Behavioral Health in the Schedule of Medical Benefits.

Note that Psychological testing that is medically necessary for the evaluation of a mental health diagnosis (e.g., serious psychiatric illness, alcohol and/or drug abuse) and medically necessary **neuropsychological testing** for evaluation of a medical diagnosis (e.g., traumatic brain injury, stroke, epilepsy, hydrocephalus, Alzheimer's disease) is considered for coverage under the Physician services row in the Schedule of Medical Benefits.

37. **Expenses for Applied Behavioral Analysis (ABA).** Applied Behavior Analysis is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior in an attempt to improve speech and social interaction skills and reduce disruptive behavior.

38. **Corrective Appliances and Durable Medical Equipment Exclusions**
    a. Expenses for any items that are not Corrective Appliances, including Orthotic Devices and/or Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document, including but not limited to swimming pools, spas, air purifiers, vehicles, elevators and exercise equipment.
    b. Expenses for replacement of **lost/missing/stolen, duplicate or personalized/characterized** Corrective Appliances, including Orthotic Devices and/or Prosthetic Appliances, or Durable Medical Equipment.
    c. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
    d. Expenses for **orthopedic or corrective shoes,** or for the fitting or casting of these items.
    e. Durable Medical Equipment purchased online through the Internet.

39. **Cosmetic Services Exclusions**
    a. Expenses for surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Medical Plan **does** cover Medically Necessary Reconstructive Services, including Reconstructive Surgery and breast reconstruction after a mastectomy and medically necessary breast reduction.
    b. To determine the extent of this coverage, see the Schedule of Medical Benefits chapter of this document. Covered individuals should use the Plan's Precertification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or Medically Necessary.

40. **Custodial Care Exclusions**
    a. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, except when Custodial Care is provided by Home Health aides as part of a covered Hospice program.
    b. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.

41. **Dental Services Exclusions**
    a. Expenses for **Dental Prosthetics or Dental services** (as listed in the definition of Dental in the Definitions chapter of this document) or dental supplies of any kind, even if they are necessary because of symptoms, illness or injury affecting another part of the body, except prescription drugs required for a dental purpose are payable under the Drug benefit of this Medical Plan.
    b. Expenses for Dental services may be covered under the Medical Plan **only if** they are incurred for the repair or replacement of an injury to teeth or restoration of the jaw if damaged by an external object in an accident. See Oral and Craniofacial Services in the Schedule of Medical Benefits and the Definitions chapter for additional information regarding these services.
    c. Expenses for the treatment of **Temporomandibular Joint (TMJ) Dysfunction or Syndrome**. See the Definition of TMJ Syndrome in this document. See the Dental Plan for coverage for TMJ dysfunction/syndrome.
    d. Expenses for **Orthognathic and other craniomandibular or maxillary or mandibular disorders for the treatment of Prognathism and Retrognathism and other aesthetic malposition of the bones of the jaw**, including but not limited to Orthodontia (terms are defined in the Definitions chapter), except when medically necessary as determined by the Plan Administrator or his/her designee.

e. Expenses for **Oral Surgery** to remove impacted teeth, gingivectomies, treatment of dental abscesses, and Root Canal (Endodontic) Therapy.
f. Expenses covered under the Dental Plan, and all expenses excluded under the Dental Plan unless coverage is specifically provided under the Schedule of Medical Benefits.
g. Expenses submitted to the medical plan **for hospital confinement or outpatient surgery facility related to diagnosis or treatment of a dental condition** or any dental preventive services.
h. Expenses for dental services such as removal of teeth including wisdom teeth, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), except as approved by the Plan Administrator.

42. **Drugs, Medicines and Nutrition Exclusions**
a. Pharmaceuticals requiring a prescription that have **not** been approved by the U. S. Food and Drug Administration (FDA); or are **not** approved by the FDA for the condition, dose, route and frequency for which they are prescribed; or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
b. Non-prescription or non-legend or over-the-counter (OTC) drugs or medicines, except insulin which is payable under Drugs, and diabetic supplies payable under Nondurable in the Schedule of Medical Benefits.
c. Foods and nutritional supplements including, but not limited to, home meals, foods, diets, vitamins and minerals except when provided during Hospitalization, and except for therapeutic vitamins requiring a prescription such as prenatal vitamins. Formula is excluded (except prescription formula that serves as the sole nutritional intake for a child or adult when prescribed by a Physician and pre-approved by the Plan Administrator).
d. Naturopathic, naprapathic or homeopathic remedies and substances.
e. Drugs, medicines or devices for:
- cosmetic purposes;
- non-prescription contraceptive products;
- fertility and/or infertility (except if such drugs are used to treat a non-fertility condition);
- topical fluoride preparations for dental purposes;
- hair growth and hair removal products used for cosmetic purposes (*i.e.* Propecia, Rogaine, Vaniqa);
- drugs for anti-aging, bodybuilding/athletic enhancement or to improve physical performance including but not limited to androgen products, anabolic steroids.

f. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
g. Vaccinations, immunizations, inoculations, vitamin injections or preventative injections, except those provided by the Plan for children and/or adults (under the Well Child and Well Adult Benefits); and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin or B12 for treatment of pernicious anemia). See the Well Child and Well Adult Benefits section of the Schedule of Medical Benefits.
h. Medical marijuana, regardless of medical necessity.

43. **Durable Medical Equipment Exclusions:** Refer to the Corrective Appliances exclusion.

44. **Fertility, Genetic, Reproductive and Sexual Dysfunction Services Exclusions**
a. Expenses for the **treatment of infertility** and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, cryostorage of egg or sperm, reversal of sterilization procedures, except certain fertility diagnosis and adoption expenses as noted under Fertility in the Schedule of Benefits.
b. Expenses for **surgical treatment of sexual dysfunction** or inadequacy, and any complications thereof.
c. Expenses for medical or surgical treatment related to **transsexual (sex change) procedures**, or the preparation for such procedures, or any complications resulting from such procedures.
d. Expenses related to **non-prescription prevention of pregnancy.**
e. Expenses for **genetic services, tests and/or procedures** except when performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women (including amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein analysis in pregnant women) and in high–risk individuals.
f. Expenses for **elective termination of pregnancy** (abortion), unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion.

45. **Foot Care Exclusions**
a. Expenses for routine foot care, including but not limited to trimming of toenails, removal of corns or callouses, removal thick/cracked skin on heels, foot massage, hygienic/and preventative care (hygienic/preventive care includes cleaning and soaking of the feet, applying skin creams to help maintain skin tone and other services that are performed when there is no evidence of a localized illness, injury or symptoms involving the foot). Expenses for hand care

including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand, unless the Plan Administrator or its designee determines such care to be medically necessary. Routine foot care (as described above) when administered by a podiatrist is payable when medically necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

46. **Genetic Testing and Counseling Exclusions**

a. **Genetic Testing**: Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, including:

- **Pre-parental genetic testing (also called carrier testing)** intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children. **No coverage for pre-parental/carrier genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents**; and
- **Prenatal genetic testing** intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits **except** when those tests are performed in accordance with state-mandated newborn screening or tests using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women.

Genetic testing and non-covered individuals: No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a covered individual. See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

Plan Participants should use the Plan's Precertification procedure to determine if proposed Genetic Testing is covered or excluded.

b. **Genetic Counseling**: Expenses for genetic counseling are excluded in every case.

47. **Hair Exclusions**

a. Expenses for hair removal or hair transplantation and other procedures to replace lost hair or to promote the growth of hair for cosmetic purposes, for the use of Propecia, Rogaine, or Minoxidil or other Prescription/non-prescription drugs or services used to promote the growth of hair, remove hair or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces, except that the Plan will provide benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy. See Corrective Appliances in the Schedule of Medical Benefits.

48. **Home Health Care Exclusions**

a. Expenses for any Home Health Care services other than part-time, intermittent skilled nursing services and supplies, except when the services of Home Health aides are payable as Home Health Care Services as described in the Schedule of Medical Benefits.
b. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
c. Expenses for a homemaker, Custodial Care, childcare, adult care or personal care attendant, except as provided as part of the Plan's Hospice coverage.

49. **Maternity/Family Planning Exclusions**

a. **Termination of Pregnancy:** Expenses for elective induced abortion unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion. **Home Delivery: Expenses f**or pre-planned home delivery. Services performed by a midwife who is not a Certified Nurse Midwife.
b. Expenses for **childbirth education, Lamaze classes**.
c. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

50. **Rehabilitation Therapies Exclusions (Inpatient or Outpatient)**

a. Expenses for educational, job training and/or vocational rehabilitation.
b. Expenses for massage therapy (except massage therapy when performed by a physical therapist or Chiropractor as part of a medically necessary rehabilitation program), rolfing and related services.
c. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is **otherwise incapable of participating in a purposeful manner with the therapy services**, including, but not limited to coma

stimulation programs and services. Continued Hospitalization for the primary purpose of providing Passive Rehabilitation (as defined in this Plan) will not be considered to be Medically Necessary for the purposes of this Plan.

d. This plan does not provide payment for admission and confinement in an inpatient rehabilitation facility to provide rehab services to a person who currently has a cognitive deficit (that is, the person is unable to learn and remember the services being taught to them).
e. Expenses for Maintenance Rehabilitation as defined in the Definitions chapter of this document.
f. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin, except as provided under the Rehabilitation section of the Schedule of Medical Benefits.
g. Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or result of a covered treatment.

51. **Sexual/Erectile Dysfunction Services Exclusions**
    a. Sex Change Counseling, Therapy and Surgery: Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

53. **Transplantation (Organ and Tissue) Exclusions**
    a. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplantation, post operative services and drugs or medicines, and all complications thereof, except those transplantation services noted under the Transplantation Services section of the Schedule of Medical Benefits.
    b. Expenses related to nonhuman (Xenografted) organ and/or tissue transplants/implants, except heart valves/skin grafts.
    c. Expenses for insertion and maintenance of an artificial organ or related device, and all complications thereof, except artificial heart, heart valves and kidney dialysis.
    d. Expenses related to the donor of any organ or tissue for transplantation, including but not limited to donor screening, donor organ or tissue removal, donor procurement fees, donor organ or tissue transport charges, except when the donor is donating to a person whose transplantation is covered under this Plan. Refer to the Transplantation section of the Schedule of Medical Benefits.

54. **Vision Care Exclusions**
    a. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), Photorefractive Keratectomy (PRK), corneal ring implants and Laser Assisted In Situ Keratomileusis (LASIK).
    b. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except one pair of eyeglasses or contact lenses provided as a Prosthetic device following lens extraction surgery. See also the separate Vision Plan in another chapter of this document.
    c. Vision therapy (orthoptics) and supplies.

55. **Weight Management and Physical Fitness Exclusions**
    a. Expenses for medical or surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof, **except** that the Plan will cover bariatric (weight loss) surgery for adult participants as outlined in the Schedule of Medical Benefits. Note however that the Plan **does not** pay for post-weight loss skin reduction surgery/treatment. See the Weight Management row in the Schedule of Medical Benefits for more information.
    b. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
    c. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility or exercise equipment for physical fitness.

IN-NETWORK AND NON-NETWORK SERVICES

You may select your medical doctor(s) or Behavioral Health Providers from one of the Network Providers or you may go to an out-of-network (Non-Network) provider of your choice. The amount of benefits paid is determined by the provider chosen. There are two networks available under this Plan:

- A network for plan participants who live in Arizona; and
- A network for plan participates who do not live in Arizona and instead live outside Arizona.

The two different networks are listed on the Quick Reference Chart in the front of this document.

IN-NETWORK SERVICES

In-Network Health Care Providers have agreements with the Plan's Preferred Provider Organizations (PPO) under which they provide health care services and supplies for a favorable negotiated fee for Plan participants. When a Plan Participant uses the services of an In-Network Health Care Provider, except with respect to any applicable Deductible, the Plan Participant is responsible for paying the applicable Coinsurance or Copay for Medically Necessary services or supplies. The In-Network Health Care Provider generally deals directly with the Plan for any additional amount due.

Preferred Providers are PPO Providers (hospitals, physicians, behavioral health providers and other ancillary medical vendors) that have agreed to a special reduction in fees to the network subscribers. Use of a preferred provider will result in the greatest discount to both you and the Plan. Preferred providers will accept payment from the plan as payment in full less any applicable deductible, coinsurance or copay that is your responsibility. The plan pays the rest.

Preferred providers are not to seek additional reimbursement from you for the difference between their billed charges and the contracted amount that is allowed by this Plan for covered services (the Allowed or Contracted Charge).

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. The City of Mesa has assumed all liability for claims payment based on the provisions and limitations stated in this plan document. No network access is available from Blue Cross Blue Shield Plans outside of Arizona.

No provider network benefits are available from Blue Cross Blue Shield of Arizona outside of Arizona.

NON-NETWORK SERVICES

Non-Network Health Care Providers (also called out-of-network providers, Non-PPO) have no agreements with the PPO or the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowed or Contracted Charge (as defined by this Plan) for any Medically Necessary covered services or supplies, subject to the Plan's Deductibles, Coinsurance, Copayments, Limitations and Exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

- **IMPORTANT NOTE: Non-Network Health Care Providers may bill you for any balance that may be due in addition to the amount payable by the Plan**.

MEDICAL COVERAGE FOR OUT-OF-STATE MEMBERS

The Plan has contracted with a network listed in the Quick Reference Chart in the Introduction chapter of this document to provide an out-of-state network for members **who live outside the state of Arizona. It is not for members who normally reside in Arizona who are traveling outside the state.** For out-of-state members who use a network provider, the Plan will reimburse the Plan Participant at the in-network benefit structure for the plan selected. For a member that uses a non-network provider, services will be processed as out-of-network.

If the City of Mesa is your primary or only carrier, the provider needs to submit the claim to the address listed in the Quick Reference Chart in the Introduction chapter of this document.

If the City of Mesa is your secondary carrier, the provider needs to submit the claim to the primary carrier first. After the primary insurance has processed the claim, send the itemized bill with the primary carrier's Explanation of Benefits to the City of Mesa at the address listed in the Quick Reference Chart in the Introduction chapter of this document.

EXCEPTIONS TO NORMAL PLAN REIMBURSEMENT FOR NON-NETWORK PROVIDERS

There are two exceptions to the Plan's payment for Non-Network Providers:

* Reason for Non-PPO Provider Use	What the Plan Pays
1. The patient had a medical emergency inside or outside the PPO service area.	The in-network benefit allowed according to the Schedule of Medical Benefits.
2. The patient had to use a non-PPO provider because there was no Preferred PPO provider who could perform the required service as determined by the Utilization Management Company.	The in-network benefit allowed according to the Schedule of Medical Benefits.

* If you are scheduled for a surgical procedure, please note that is your responsibility to ensure that ALL providers involved (such as the surgeon, anesthesiologists, assistant surgeons) and the facility are in-network providers.

UTILIZATION MANAGEMENT (UM)

PURPOSE OF THE UTILIZATION MANAGEMENT (UM) PROGRAM

Your Plan is designed to provide you and your covered family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-**increasing cost of providing health care may make it difficult for the City to afford the cost of maintaining your Plan.**

To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the City is better able to afford to maintain the Plan and all its Benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, **if you don't follow these procedures, your Plan provides reduced Benefits, and you'll be responsible for paying more out of your own pocket.**

The Plan's Utilization Management Program consists of:

1. **Precertification (Preservice) Review:** Review of proposed health care services **before** the services are provided;
2. **Concurrent (Continued Stay) Review:** Ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Specialized Health Care Facility;
3. **Second and Third Opinions:** Consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain Elective health care services;
4. **Retrospective Review:** Review of health care services **after** they have been provided; and
5. **Case Management:** A process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the City work together under the guidance of the Plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

MANAGEMENT OF THE UTILIZATION MANAGEMENT PROGRAM

The Plan's Utilization Management Program is administered by an independent professional Utilization Management Company (hereafter referred to as the UM Company) operating under a contract with the Plan. Their name and phone number is listed on the Quick Reference Chart in the Introduction chapter of this document. (Certain classes of prescription drugs must also be precertified. You or your doctor can do this by calling the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document).

The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

VERY IMPORTANT INFORMATION ABOUT RESTRICTIONS & LIMITATIONS OF THE UM PROGRAM

1. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Specialized Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be considered Medically Necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan Benefits. The UM Company's certification that a service is Medically Necessary doesn't mean that a Benefit payment is guaranteed. Eligibility for and actual payment of Benefits are subject to the terms and conditions of the Plan as described in this document. For example, Benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if the UM Company does not certify a proposed Surgery or other proposed medical treatment as Medically Necessary; or the Plan will not pay regular Plan Benefits for a Hospitalization or confinement in a Specialized Health Care Facility because the UM Company does not certify a proposed confinement;

4. The Benefits payable by the Plan may, however, be affected by the determination of the UM Company.
5. With respect to the administration of this Plan, the Employer, the Plan and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company as Medically Necessary.

PRECERTIFICATION (PRESERVICE) REVIEW

Precertification Review is a procedure, administered by the Utilization Management (UM) Company, to assure that the admission and length of stay in a Hospital or Specialized Health Care Facility, Surgery, and other health care services (including certain invasive procedures, sleep studies, Durable Medical Equipment exceeding $1,000, to name a few) are Medically Necessary.

The UM Company's medical staff use established medical standards to determine if recommended Hospitalizations, confinements in Specialized Health Care Facilities, Surgery and/or other health care services meet or exceed accepted standards of care. See the Section titled Very Important Information About Restrictions and Limitations of the Utilization Management Program in this chapter.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

Under this Plan, the plan participant (employee, retiree or spouse) is responsible to properly precertify the services requiring pre-approval, on behalf of themselves or their covered family members, including children.

While the physician's office may provide the Utilization Management company with specific medical or surgical information related to a case, **it is ultimately the plan participant's responsibility to assure that the precertification process has been completed**.

WHAT SERVICES MUST BE PRECERTIFIED? (i.e. approved before they are provided)

The following must be precertified by the Utilization Management Company:

1. All **Elective non-emergency Hospital admissions** and behavioral health admissions. Note: precertification is required for pregnant women with hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
2. All **Elective admissions** to any Specialized Health Care Facility including:
   - **Outpatient Surgery in a free-standing or hospital-based surgery center/facility**
   - **Hospice**
   - **Skilled Nursing Facility (SNF)**
   - **Subacute Facility**
3. All admissions to any **Inpatient or Day-treatment Rehabilitation facility or program**.
4. All **Home Health Care and Home Infusion Services.**
5. All surgical or invasive procedures performed **in a physician's office in which the total cost per surgical session is estimated to cost $500 or more**. This does NOT include non-invasive diagnostic tests.
6. Precertification is required **prior to the beginning of speech therapy treatment**. Once speech therapy has been certified as Medically Necessary no further certification is required.
7. **Durable Medical Equipment (DME) with an estimated cost over $1,000 per piece of equipment.**
8. **Transplantation services.**
9. **Bariatric (Weight Management) Surgery.**
10. **Genetic counseling, evaluation and testing for BRCA**, both counseling and testing need to be pre-certified.

NOTE: Certain classes of prescription drugs must be precertified by the Prescription Drug Program as noted under Drugs on the Schedule of Medical Benefits.

How to Request Precertification from the Utilization Management Company:

You or your Physician must call the UM Company at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction chapter of this document. Calls for Elective services should be made at least **7 days** before the expected date of service.

Emergency Admissions must be precertified within 48 hours (see below). Calls to the UM Company may be made 24 hours/day, 7 days/week. If you are not sure whether a procedure needs to be precertified, just call the UM Company.

The caller should be prepared to provide all of the following information:

1. the employer's name;
2. the employee's name, address, phone number and insured identification number;
3. the patient's name, address, and phone number (if different from the employee)
4. the Physician's name, address, phone number;
5. the name of any Hospital, Specialized Health Care Facility or any other Health Care Provider that will be providing services along with the reason for the health care services or supplies; and
6. the proposed date for performing the services or providing the supplies.

If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Physician and the Hospital, Specialized Health Care Facility, any other Health Care Provider, and the Benefits Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company will usually respond to your treating Physician or other Health Care Provider by telephone within 3 working days after it receives the request and any required medical records and/or information, and its determination will then be confirmed in writing.

Appeal of a Denial of Precertification from the Utilization Management Company

See the Claims and Appeal chapter for details on how to appeal and the timeframes for appealing a Um decision.

CONCURRENT (CONTINUED STAY) REVIEW BY THE UTILIZATION MANAGEMENT COMPANY

How Concurrent (Continued Stay) Review Works: When you are receiving medical services in a Hospital or Specialized Health Care Facility, the UM Company may contact your Physician or other Health Care Providers to assure that continuation of medical services is Medically Necessary and help coordinate your medical care with the Benefits available under the Plan. Concurrent Review may include such services as:

1. coordinating Home Health Care or the provision of Durable Medical Equipment;
2. assisting with discharge plans;
3. determining the need for continued medical services; and/or
4. advising your Physician or other Health Care Providers of the various options and alternatives available under this plan for your medical care.

No Benefits will be paid for any charges related to days of confinement to a Hospital or other Specialized Health Care Facility that have not been determined to be Medically Necessary by the UM Company.

Appeal of a Denial of a Concurrent Review:

See the Claims and Appeal chapter for details on how to appeal and the timeframes for appealing a Um decision.

EMERGENCY HOSPITALIZATION

If an Emergency requires Hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the **UM Company must be notified of the Hospital admission within 48 hours**. Your Physician, a family member or friend can make that phone call. This will enable the UM Company to assist with discharge plans, determining the need for continued medical services, and/or advising your Physician or other Health Care Providers of the various recommendations, options and alternatives for your medical care.

PREGNANCIES

It is recommended but not required, that pregnant women notify the UM Company as soon as possible once they know they are pregnant.

SECOND AND THIRD OPINIONS

How the Second and Third Opinion Process Works: At any time during the review process, you may be asked by the UM Company to obtain a Second Opinion about a proposed health care service to help determine if the health care service is Medically Necessary, or if an alternative effective approach to the individual patient's health care management exists. A Second Opinion may be requested when it appears that:

1. there may be a question regarding the effectiveness or reliability of a proposed service;
2. the proposed service involves a high risk in relation to the anticipated benefit; or
3. there appear to be conflicting diagnoses, vague indications, or questions concerning clinical management.

If a Second Opinion is required, the UM Company will arrange for an examination by a Physician who:

1. is certified by the American Board of Medical Specialists in the field related to the proposed service;
2. is independent of the Physician who proposed the service.

The Second Opinion Physician may review past medical records along with clinical findings from his or her own examination of the patient, and will report his or her findings to the UM Company. If the Second Opinion recommendation differs from the treating Physician's recommendation, you may be required to obtain a Third Opinion from another Physician who will be selected in the same manner as the Second Opinion Physician. The results of the Third Opinion will be reviewed by the UM Company, and the recommendation of the majority of the Physicians (the attending Physician, and the Second and Third Opinion Physicians) will prevail.

If, as a result of the Second and/or Third Opinion, it is determined that the procedure recommended by the treating Physician is not Medically Necessary, **no Benefits will be payable if you choose to undergo the procedure**. See also the section titled Failure to Follow Required Utilization Management Procedures.

Patient-Requested Second and Third Opinions: If the UM Company does not require a Second Opinion, but you or your covered Dependent requests one, it will be provided in the manner described in the preceding section, except that you or your covered Dependent may get the Second Opinion from any Physician (however the coinsurance payable by the Plan may vary according to use of in-network and non-network providers).

Appeal of a Second or Third Opinion That Disagrees with a Recommended Procedure: If the Second or Third Opinion disagrees with the procedure recommended by the treating Physician, and the disagreement cannot be resolved by discussion between the treating and reviewing Physicians, you and/or your Physician may submit a written appeal of the decision, accompanied by any additional information to support the need for the proposed health care service.

The appeal, with supporting information, should be sent to the UM Company at the office or to the fax number shown in the Quick Reference Chart in the Introduction chapter of this document. The UM Company will respond in writing within 30days after it receives the request and any required medical records and/or information.

Cost of the Second and Third Opinions: The Plan will pay the full cost for any Second and Third Opinion required by the UM Company; and a percentage of the cost (set forth in the Schedule of Medical Benefits describing the Second and Third Physician Opinions) for any Second and Third Opinion not required by the Plan but requested by the patient.

RETROSPECTIVE REVIEW BY THE UTILIZATION MANAGEMENT COMPANY

All claims for medical services or supplies that have not been reviewed under the Plan's Precertification, Concurrent (Continued Stay) Review, or Second and Third Opinion Programs may be subject to retrospective review, at the option of the Benefits Claims Administrator, to determine if they are Medically Necessary. If the Benefits Claims Administrator determines that the services or supplies were not Medically Necessary, **no Benefits will be provided by the Plan for those services or supplies.** After your Claim has been processed, you may request a review of the Claim decision. **For complete information on Claim Review, see the Claim Information chapter of this document.**

CASE MANAGEMENT

How Case Management Works: Case Management is a process, administered by the Utilization Management (UM) Company. Its medical professionals work with the patient, family, care-givers, Health Care Providers, Benefits Administrator and the Company to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers. See also the section titled Failure to Follow Required Utilization Management Procedures in this chapter.

Working with the Case Manager: Any Plan Participant, Physician or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction chapter of this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Physician, Hospital, and/or other Specialized Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Physician may call the Case Manager at any time at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction chapter of this document to ask questions, make suggestions, or offer information.

FAILURE TO FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES

If you do not follow the Precertification Review, Concurrent (Continued Stay) Review, or Case Management procedures, or if you fail to obtain a required Second or Third Opinion, or if you undergo a medical procedure that has not been determined to be medically necessary, **claims for these services may be denied.**

EMPLOYEE ASSISTANCE PROGRAM (EAP) BENEFITS

THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

This chapter describes the Employee Assistance Program (EAP) benefits available to all employees and their dependents. Retirees are not eligible for this service.

The City of Mesa offers an Employee Assistance Program (EAP) to employees and their family members which provides confidential counseling and referral **services at no charge to the member up to a maximum of eight (8) visits per person per issue per year**. The EAP program offers a comprehensive website that includes legal, financial, ID theft, eldercare and childcare resources; this includes telephone and internet chat consultations with legal, financial, eldercare and childcare specialists. The legal consultation includes a free 30-minute evaluation appointment and a 25% discount if the local lawyer is selected.

The EAP is an employer-paid benefit and is a benefit designed to help you and your family members with personal problems. Counseling is short-term and confidential. All counseling and referral services are offered at no charge to you or your dependents.

Call (602) 264-4600, option 2, or 1 (800) 327-3517, option 2 or, visit www.eappreferred.com, username is COM123, password is "eappreferred."

All employees are eligible to use the services offered by the EAP immediately upon becoming employed by the City of Mesa, regardless of their full-time or part-time status. Family members are also eligible and **do not have to be enrolled** in one of the City's medical plans in order to make an appointment with one of the counselors.

Behavioral Health benefits for extended behavioral health care are available to individuals (employees, retirees and their covered family members) enrolled in one of the Medical plans offered by the City, and are described in the Behavioral Health section of the Schedule of Medical Benefits in this document.

DENTAL PLAN BENEFITS

These self-funded Dental Plan benefits are treated as a standalone (or excepted) benefit under Health Care Reform (PPACA).

The Dental Plan Options: The City offers three Dental Plan Options to plan enrollees, described below. You and all your family members who are enrolled for dental coverage must all be enrolled in the same plan option.

- **Dental Choice Plan:** This plan option is a coinsurance plan allowing you to use any dental provider for preventative, basic and major restorative dental services. No coverage for orthodontia.
- **Dental Choice Plus Plan**: This plan option is a coinsurance plan allowing you to use any dental provider for preventative, basic and major restorative dental services along with coverage for orthodontia.
- **Preventative Choice Plan**: This plan option is a coinsurance plan allowing you to use any dental provider for preventative and basic restorative dental services only. No coverage for major dental services or orthodontia.

Covered Dental Expenses: You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider (as defined in the Definitions chapter of this document) that are determined by the Plan Administrator or its designee to be "**Medically Necessary,"** but only to the extent that the Plan Administrator or its designee determines that the services are the most cost effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and the charges for them are "Allowed or Contracted Charges**."** See the Definitions chapter of this document for the definitions of "Medically Necessary" and "Allowed or Contracted Charge."

Non-Eligible Dental Expenses Explained: The Plan will not reimburse you for any expenses that are not Eligible Dental Expenses, including any services received prior to the individual's effective date for dental coverage. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be an Allowed or Contracted Charge.

This chapter of the document explains which expenses for dental services and supplies are covered (i.e., which are Eligible Dental Expenses) and which are not. Generally, the Plan will not reimburse you for all Eligible Dental Expenses. Usually, you will have to satisfy some **Deductible** and pay some **Coinsurance** toward the amounts you incur that are Eligible Dental Expenses.

Eligibility for Orthodontia Services: Orthodontia benefits are only available to eligible dependent children age 18 and under. A dependent child is no longer eligible for orthodontia benefits **on or after** his/her 19th birthday.

DEDUCTIBLES

Dental Deductible for Individual and Family: Each calendar year, you are responsible for paying all your Eligible Dental Expenses classified as Restorative treatment, until you satisfy the annual Deductible. Then, the Dental Plan begins to pay benefits. There are two types of Deductibles: Individual and Family.

- The Individual Deductible is the maximum amount one covered person has to pay before Plan benefits begin. **The Plan's Individual Dental Deductible is $100.**
- The Family Deductible is the maximum amount that a family of three or more has to pay before Plan benefits begin. **The Plan's Family Dental Deductible is $300.** If you have a family and there are less than three eligible members in your family, each individual must meet his/her individual deductible before benefits will be paid. If however, your family includes more than three eligible members, your family deductible will be based on expenses for all eligible family members with no more than $100 applied to any one individual.

Eligible Dental Expenses incurred for Preventive (and, where applicable, Orthodontia) Services **ARE NOT** subject to the Dental Deductible.

COINSURANCE

Coinsurance Explained: Once you've met your annual Deductible, the Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest. The applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits. The part you pay is called the Coinsurance. Eligible Dental Expenses incurred for Preventive Services are not subject to Coinsurance.

OUT-OF-POCKET EXPENSES

Out-of-Pocket Expenses You Are Responsible for Paying Yourself: Under this Plan, each calendar year, you will be responsible for paying, out of your pocket, the following expenses for dental services and supplies:

1. Your Individual or Family Deductible.
2. Any applicable Coinsurance, subject to the Overall and/or Annual Maximum Dental Plan Benefits shown below.
3. All expenses for dental services or supplies that are **not** covered by the Plan.
4. All charges in excess of the Allowed or Contracted Charge determined by the Plan Administrator or its designee.

MAXIMUM PLAN BENEFITS

- **Annual Maximum Dental Plan Benefits:** The maximum annual dental plan benefit payable for dental expenses for any individual is displayed on the Schedule of Dental Benefits and varies according to the Dental Plan you choose. Some Preventive Dental Services are not subject to the annual maximum Dental plan benefits (see the Schedule of Dental Benefits for details).
- **Overall Lifetime Maximum Orthodontia Plan Benefits**: The Overall "Lifetime" Maximum Plan Benefits payable for Orthodontia services for any eligible dependent child covered under this Plan is $2,400, while the Annual Maximum Plan Benefit is $1,200.

GUIDELINES ON PLAN PAYMENT IF DENTAL COVERAGE ENDS (Extension of Dental Benefits)

If dental coverage ends, this Plan will continue to pay Dental Plan benefits (but not orthodontia benefits) for you or your covered dependents **only for certain conditions** noted below:

1. A Prosthesis (such as a bridge or full or partial Denture), if the Dentist took the impressions and ordered the prosthesis prior to termination under the dental plan AND delivers and installs the device within 30 days after coverage ends.
2. A Crown, if the Dentist prepared the Crown while you were covered and installs it within 30 days after coverage ends.
3. Root canal treatment, if the Dentist opened the tooth while you were covered and completes the treatment within 30 days after coverage ends.

These extended dental benefits do NOT apply to orthodontia services.

See also the section on Continuation of Coverage (COBRA) for information on how to continue dental coverage when eligibility under the Dental Plan ceases.

SCHEDULE OF DENTAL BENEFITS

A chart outlining a description of the Plan's Dental benefits and the explanations of them appears on the following pages.

SCHEDULE OF DENTAL BENEFITS

This table explains what the Plan pays. All benefits are determined according to Allowed or Contracted Charge allowances as defined in this document.
See the Definition and Exclusions chapters of this document for important information on Plan benefits.

Benefit Description	Explanations and Limitations	Dental Choice Plan	Dental Choice Plus Plan	Preventative Choice Plan
Annual Maximum Payable for Dental Services		$1,200 per person per calendar year	$1,500 per person per calendar year	$500 per person per calendar year
Dental Plan Deductible per Calendar Year		$100/person $300/family (applies to Basic & Major Restorative services only)		
Preventive Services • Oral examination. • Prophylaxis (cleaning of the teeth). • Bitewing x-rays and Full mouth x-rays. • Examination in connection with emergency palliative treatment***.** • Examination for consultation purposes***.** * *these services apply toward the Annual Maximum Dental Plan benefits*.	• **Preventive services are NOT subject to the Annual Maximum Plan Benefits except where marked with an asterisk*.** • Oral examination is limited to twice per calendar year. • Prophylaxis, scaling, cleaning and polishing is limited to twice per calendar year. • Bitewing x-rays are limited to twice per calendar year. • Full mouth or Panoramic x-rays limited to once in a period of 36 consecutive months.	100% of Allowed or Contracted Charges, no deductible	100% of Allowed or Contracted Charges, no deductible	100% of Allowed or Contracted Charges, no deductible
Orthodontia Services • Necessary services related to an active course of orthodontia treatment including diagnosis, evaluation and pre-care. • The initial installation of orthodontic appliances for an active course of orthodontia treatment. • Adjustment of active orthodontia appliances. • This orthodontia benefit is for non-surgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. • Expenses related to orthodontia will be covered only when one or more of the conditions noted to the right have been satisfied.	• Orthodontia services are subject to Annual and Overall Lifetime Maximum Dental Plan benefits. • **Orthodontia services are limited to Dependents under age 19.** • Payment for orthodontia benefits will **not continue** if treatment ceases **for any reason**. Repair of orthodontia appliances is **not covered**. • **Orthodontia treatment that is started before the patient's effective date with the City of Mesa Health Plan is not reimbursable under this Plan option**.	Not covered	80% of Allowed or Contracted Charges, no deductible • Maximum payable is $1,200/yr • Maximum payable is $2,400 per lifetime.	Not covered
Basic Restorative Services • Topical application of sodium or stannous fluoride. • Application sealants. • Tooth extractions. • Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed or broken teeth.	• Sealants limited to dependent children under age 19.	80% of Allowed or Contracted Charges, after deductible	80% of Allowed or Contracted Charges, after deductible	80% of Allowed or Contracted Charges, after deductible

SCHEDULE OF DENTAL BENEFITS

This table explains what the Plan pays. All benefits are determined according to Allowed or Contracted Charge allowances as defined in this document.
See the Definition and Exclusions chapters of this document for important information on Plan benefits.

Benefit Description	Explanations and Limitations	Dental Choice Plan	Dental Choice Plus Plan	Preventative Choice Plan

Major Restorative Services
• Dental x-rays for diagnosis of a dental condition.
• Injection of necessary antibiotic drugs by attending Dentist.
• Space maintainers.
• Periodontal prophylaxis and treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone).
• Occlusal adjustment.
• Oral surgery, including extractions and surgical procedures.
• Administration of general anesthesia and/or intravenous sedation only in connection with covered oral surgery services. Administration of local anesthesia in connection with covered dental services.
• Endodontic treatment, including root canal therapy.
• Onlays and crowns, including repair or re-cementing of crowns, inlays or onlays.
• Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth that were extracted.
• Dentures and cast inlays, including adjusting, relining or re-basing of removable dentures. Replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture; bridgework to replace extracted teeth if evidence, satisfactory to the Plan Administrator or its designee, is presented that the conditions shown to the right have been satisfied
• Precision/semi-precision attachments for prosthetic devices.
• Gold restorations if teeth cannot be restored with other materials.
• Treatment of Temporomandibular Joint Syndrome/Dysfunction (TMJ). See also TMJ treatment in the Medical Plan.
• Expenses for dental services or appliances to stabilize tooth structure lost by wear or bruxism (clenching/grinding of teeth) and devices for harmful habits such as thumb-sucking.
	• Restorative services are **subject to Annual Maximum Plan Benefits.**
	• Oral surgery is limited to removal of impacted teeth or as necessary for teeth covered partially or totally by bone, root canal treatment or gingivectomy.
	• Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition are NOT covered under this dental plan. Contact your medical plan to determine if such services are reimbursable under a medical plan.
	• Outpatient prescription drugs and medicines prescribed by a Dentist are NOT payable under this dental plan. Contact your medical plan to determine if such services are payable under a medical plan.
	• For replacement of an existing partial or full removable denture, the following applies
	  • The replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed.
	  • The existing denture or bridgework cannot be made serviceable and was installed at least 3 years prior to the replacement date.
	  • The existing denture is an immediate temporary denture replacing one or more natural teeth. Replacement by a permanent denture is required. The replacement must take place within 12 months from the placement of the temporary denture.
	  • The replacement is due to accidental injury requiring oral surgery and the replacement takes place within 3 years of the accident.
		80% of Allowed or Contracted Charges, after deductible	80% of Allowed or Contracted Charges, after deductible	Not covered

DENTAL PLAN EXCLUSIONS

The following is a list of dental services and supplies or expenses **not covered** by any of the Dental Plan options. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Dental Plans has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

1. **Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis, nitrous oxide and/or related services provided for apprehension or anxiety, except when approved by the Plan Administrator for use of nitrous oxide on children with complex dental and oral surgical procedures.
2. **Bacteriologic studies and susceptibility testing** for dental caries (cavities) not covered.
3. **Cosmetic Services:** Expenses for dental Surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to veneers and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under your Medical Expense Coverage:
   - Reconstructive dental Surgery when that service is incidental to or follows Surgery resulting from trauma, infection or other diseases of the involved part;
   - Surgery or treatment to correct deformities caused by sickness;
   - Surgery or treatment to correct birth defects outside the normal range of human variation;
   - Reconstructive dental Surgery because of congenital disease or anomaly of a covered Dependent Child that has resulted in a functional disorder;
4. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
5. **Drugs and Medicines:** Expenses for outpatient prescription drugs and medications.
6. **Duplicate or Replacement Lost, Stolen or Missing Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement Bridge, Denture or Orthodontic Appliance.
7. **Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one Dentist to the care of another Dentist during the course of any treatment, or if more than one Dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had only one Dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.
8. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation, Annual Maximum Plan Benefits, or Overall Maximum Plan Benefits as described in the Dental Plan Benefits chapter of this document.
9. **Expenses Exceeding Allowed** or Contracted **Charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed or Contracted Charge as defined in the Definitions chapter of this document.
10. **Expenses related to complications of a non-covered service.**
11. Expenses for and related to **cryostorage of stem cells in teeth or other tissue.**
12. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Dental Plan; or after the date the patient's coverage ends, except under those conditions described in the section entitled "Guidelines on Plan Payment if Dental Coverage Ends" in the Dental Benefits chapter of this document.
13. **Experimental and/or Investigational Services:** Expenses for any dental services and supplies that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
14. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan
15. **Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings for jaw movement and position.
16. **Home Use Supplies:** Expenses for home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.

17. **Hospital Expenses Related to Dental Care:** Expenses for Hospitalization related to Dental Services or use of an outpatient surgical facility related to Dental Services or care except as pre-approved by the Plan Administrator.
18. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission or attempted commission of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. Upon receipt of notification of denial, the individual then has the right to appeal the denial of claims payment related to the injury or illness resulting from or sustained as a result of the alleged illegal act. Such appeal should be directed to the Plan Administrator who will submit it through the Appeal Process outlined in the Claims Information chapter of this plan document.
19. **Implantology:** Expenses for implantology (implants are artificial root structures placed into the jaw to support bridgework or dentures).
20. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
21. **Mouth Guards:** Expenses for athletic mouth guards and associated devices.
22. **Myofunctional Therapy:** Expenses for myofunctional therapy.
23. **No-Cost Services:** Expenses for dental services or supplies which a covered person is not required to pay or which are obtained without cost; or there would be no charge if the person receiving treatment were not covered under this Plan.
24. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Dentist or other Dental Care Provider, covered person or family member of a covered person.
25. **Occupational Illness/Injury or Third Party Expenses:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law; or expenses for services or supplies for which another person, entity or third party may be liable for any payment. See the Coordination of Benefits Chapter for more information.
26. **Oral Hygiene and/or Dietary Instruction:** Expenses for oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth).
27. **Orthodontia That Started Before Coverage Began:** Expenses for any dental services relating to any active course of Orthodontic treatment that began before the effective date of coverage under this Plan, even if those services are provided after the effective date of coverage under this Plan.
28. **Orthognathic services, surgery**: Expenses for orthognathic treatment including surgical procedures.
29. **Periodontal Splinting:** Expenses for periodontal splinting.
30. **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any Dental Prosthesis, including but not limited to any Bridge, Denture, Retainer or Appliance.
31. **Pictures/Photographs:** Expenses related to pictures (photographs) of teeth and/gums.
32. **Relatives Providing Services:** Expenses for dental services provided by any Dentist or other Dental Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
33. **Sealants for Individuals age 19 and older.**
34. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).
35. **Services that are an integral component of a covered treatment (e.g. unbundling)**.
36. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

VISION PLAN BENEFITS

The Vision Care Plans available to employees and eligible dependents are provided by an independent Vision Care Plan insurance company whose name and telephone number are listed on the Quick Reference Chart in the Introduction chapter of this document. This chapter briefly outlines information about the insured Vision Plan coverage; and for a more detailed explanation, contact the Employee Benefits Administration Office or refer to your online resource at InsideMesa.

These insured Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.

This Plan provides professional vision care for persons covered under the plan, through a network of contracted preferred vision professionals. There are two options for vision coverage available: **Basic Vision Plan and Vision Plus Plan**. The primary difference is in the frequency of coverage for eyeglasses and contact lenses. The Vision Plan is designed to cover visual needs rather than cosmetic materials.

All full-time and eligible part-time City of Mesa employees and eligible retirees may elect coverage under either the Basic Vision Plan or Vision Plus Plan.

To Obtain Vision Services, please contact the Vision Care Plan whose name and telephone number are listed in the Quick Reference Chart in the Introduction chapter of this document.

Services Provided: The following is a list of covered services under the Vision Care Plans. Services described below, when provided by a doctor contracted with the Vision Care Plan vendor, are at no additional expense to you except for a deductible and any additional expenses over and above wholesale allowances.

SCHEDULE OF VISION BENEFITS FOR THE BASIC VISION PLAN (12/24/24)
This chart shows what the Plan pays.

Covered Vision Benefits	Explanations and Limitations See also the Vision Plan Exclusions section.	Basic Plan Pays	
		In-Network Preferred Vision Provider	Non-Network Provider
Vision Examination (does not include contact lens fitting)	• One vision exam is payable **once each 12 months.**	Covered in full after a $10 copay per exam.	Up to $40 per exam.
Frames for Eyeglasses	• One frame is payable **once each 24 months**. • Frame Allowed Amount: You can receive a $50 wholesale frame allowance (retail value of $130) at an In-Network Preferred Vision Provider.	Covered in full after a $10 copay to a maximum of $130. Any frame over $130, the excess cost will be at a 20% discount to you. The copay is a single payment that applies to the entire eyeglasses (frames and lenses) or contacts in lieu of eyeglasses.	Up to $45.

SCHEDULE OF VISION BENEFITS FOR THE BASIC VISION PLAN (12/24/24) This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** **See also the Vision Plan Exclusions section.**	**Basic Plan Pays**	
		In-Network **Preferred Vision Provider**	**Non-Network Provider**
Lenses for Eyeglasses	• A single vision, lined bifocal, lined trifocal or lined lenticular lens is covered **once each 24 months**. • Standard lenses are covered meaning, CR-39 basic plastic or white (clear) glass lenses. • Standard scratch coating on lenses is available at a discount. • Polycarbonate lenses, tinted lenses, UV coated lenses, basic progressive lenses and other upgrades are available at a discounted fee. • Members who have had laser vision surgery can use their frame allowance to buy non-prescription sunglasses from their In-Network Vision provider. • Nonprescription sunglasses are available from In-Network Vision providers at a 20% discount.	The following types of standard lenses are covered in full: Single Vision Lined Bifocal Lined Trifocal Lined Lenticular Progressive and Oversized lenses are offered at a discounted rate to you. The copay is a single payment that applies to the entire eyeglasses (frames and lenses) or contacts in lieu of eyeglasses.	Single Vision: Up to $40. Bifocal: Up to $60. Trifocal: Up to $80. Lenticular: Up to $100.
Laser Vision Surgery or Refractive Eye Surgery		While refractive eye surgery is not a covered benefit of this Vision Plan, you can receive access to discounted refractive eye surgery from numerous providers located throughout the US. Contact the Vision Care Plan for the location of a participating network provider.	No coverage

SCHEDULE OF VISION BENEFITS FOR THE BASIC VISION PLAN (12/24/24) This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** **See also the Vision Plan Exclusions section.**	**Basic Plan Pays**	
		In-Network **Preferred Vision Provider**	**Non-Network** **Provider**

Elective Contact Lenses:
 	
Contact lenses are available in lieu of eyeglasses.
	• Contact lenses are payable **once each 24 months** in lieu of all other lens and frame benefits. When contact lenses are obtained you are not eligible for lenses and frames again for two plan years.
	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under the Vision Plan.
	• You may use your contact lens allowance toward permanent and/or disposable lenses (max 6 boxes). Covered lenses vary by the provider under contract to the Vision network.
	• Contact the Vision Care Plan to determine whether your contacts will be considered Elective or Medically Necessary. Medically necessary contact lenses are determined by the Vision Care plan and may be considered for the following reasons:
	  • following cataract surgery without intraocular lens implant; or
	  • to correct extreme visions problems that cannot be corrected with spectacle lenses, etc.
	  • when prescribed by a doctor for certain medical or visual/refractive conditions that prevent a patient from obtaining the best visual correction with glasses. Patients must meet certain criteria in order to qualify for Medically Necessary Contact Lenses.
	• Contact lenses that do not meet the above criteria are considered "not medically necessary" or elective.
	• Toric, gas permeable and bifocal contact lenses are available at an added fee.
		Elective Lenses:
		Up to $200 for fitting fees and purchase of contact lenses
		
		Medically Necessary Contact Lenses:
		Covered in full after a $10 copay
			Elective Lenses:
			Up to $200
			
			Medically Necessary Contact Lenses:
			Up to $250

Low Vision Benefit	• Is available to people who have severe visual problems that are not correctable with regular lenses. • Includes complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. • Maximum benefit is $1,000 (excluding copayment) every two years.	Supplemental Testing: Covered in full Supplemental Aids: Plan pays 75% of the cost You pay 25% of the cost	Supplemental Testing: Up to $125 Supplemental Aids: Plan pays 75% of the Allowed Charge for an In-network provider. You pay 25% of the Allowed Charge for an In-Network provider.

SCHEDULE OF VISION BENEFITS FOR THE VISION PLUS PLAN (12/12/12) This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** **See also the Vision Plan Exclusions section.**	**Plus Plan Pays**	
		In-Network **Preferred Vision Provider**	**Non-Network** **Provider**
Vision Examination (does not include contact lens fitting)	• One vision exam is payable once each 12 months.	Covered in full after a $10 copay per exam.	Up to $40 per exam.
Frames for Eyeglasses	• One frame is payable once each 12 months. • Frame Allowed Amount: You can receive a $50 wholesale frame allowance (retail value of $130) at an In-Network Preferred Vision Provider.	Covered in full after a $10 copay The copay is a single payment that applies to the entire eyeglasses (frames and lenses) or contacts in lieu of eyeglasses.	Up to $45.
Lenses for Eyeglasses	• A single vision, lined bifocal, lined trifocal or lined lenticular lens is covered **once each 12 months**. • Standard lenses are covered meaning, CR-39 basic plastic or white (clear) glass lenses. • Standard scratch coating on lenses is available at a discount. • Polycarbonate lenses, tinted lenses, UV coated lenses, basic progressive lenses and other upgrades are available at a discounted fee. • Members who have had laser vision surgery can use their frame allowance to buy non-prescription sunglasses from their In-Network Vision provider. • Nonprescription sunglasses are available from In-Network Vision providers at a 20% discount.	The following types of standard lenses are covered in full: Single Vision Lined Bifocal Lined Trifocal Lined Lenticular Progressive and Oversized lenses are offered at a discounted rate to you. The copay is a single payment that applies to the entire eyeglasses (frames and lenses) or contacts in lieu of eyeglasses.	Single Vision: 100%, up to $40. Bifocal: 100%, up to $60. Trifocal: 100%, up to $80. Lenticular: 100%, up to $100.
Laser Vision Surgery or Refractive Eye Surgery		While refractive eye surgery is not a covered benefit of this Vision Plan, you can receive access to discounted refractive eye surgery from numerous providers located throughout the US. Contact the Vision Care Plan for the location of a participating network provider.	No coverage

SCHEDULE OF VISION BENEFITS FOR THE VISION PLUS PLAN (12/12/12) This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** **See also the Vision Plan Exclusions section.**	**Plus Plan Pays**	
		In-Network **Preferred Vision Provider**	**Non-Network** **Provider**

Elective Contact Lenses:
 	
Contact lenses are available in lieu of eyeglasses.
	• Contact lenses are payable **once each 12 months** in lieu of all other lens and frame benefits. When contact lenses are obtained you are not eligible for lenses and frames again for one plan year.
	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under the Vision Plan.
	• You may use your contact lens allowance toward permanent and/or disposable lenses (max 6 boxes). Covered lenses vary by the provider under contract to the Vision network.
	• Contact the Vision Care Plan to determine whether your contacts will be considered Elective or Medically Necessary. Medically Necessary contact lenses are determined by the Vision Care plan and may be considered for the following reasons:
	  • Following cataract surgery without intraocular lens implant; or
	  • to correct extreme visions problems that cannot be corrected with spectacle lenses, etc.
	  • when prescribed by a doctor for certain medical or visual/refractive conditions that prevent a patient from obtaining the best visual correction with glasses. Patients must meet certain criteria in order to qualify for Medically Necessary Contact Lenses.
	• Contact lenses that do not meet the above criteria are considered "not medically necessary" or elective.
	• Toric, gas permeable and bifocal contact lenses are available at an added fee.
		Elective Lenses:
		Up to $200
		for fitting fees and
		purchase of contact lenses
		
		Medically Necessary
		Contact Lenses:
		Covered in full
		after a $10 copay
			Elective Lenses
			Up to $200
			
			Medically Necessary
			Contact Lenses:
			Up to $250

Low Vision Benefit	• Is available to people who have severe visual problems that are not correctable with regular lenses. • Includes complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. • Maximum benefit is $1,000 (excluding copayment) every two years.	Supplemental Testing: Covered in full Supplemental Aids: Plan pays 75% of the cost You pay 25% of the cost	Supplemental Testing: Up to $125 Supplemental Aids: Plan pays 75% of the Allowed Charge for an In-network provider. You pay 25% of the Allowed Charge for an In-network provider.

Lenticular means a vision lens of high diopter power with the prescription ground only into the central portion of the lens while the periphery of the lens usually does not contain any power correction and serves only to give dimensions suitable for mounting in a frame. The lenticular lens design helps reduce the thickness of the lens, making it lighter weight and more cosmetically and functionally appealing.

SERVICES NOT COVERED BY THE VISION PLANS (EXCLUSIONS):

There are no benefits under this vision plan for professional services or materials for:

1. Orthoptics or vision training and any supplemental testing;
2. Plano (non-prescription or less than a + or - .50 diopter power) lenses; or two pair of lenses in lieu of bifocals;
3. Replacement of lost or broken lenses or frames, except when the patient is normally eligible for services;
4. Medical or surgical treatment of the eyes (including refractive eye surgery); Corrective vision treatment of an experimental nature.
5. Any eye examination required by an employer as a condition of employment;
6. Services or materials provided as a result of any Workers' Compensation Law, or similar legislation, or any services or materials obtained through, or required by any government agency;
7. Any services or materials provided by any other vision care plan, and/or group benefit plan containing benefits for vision care.
8. Costs for services and/or materials above Plan Benefit allowances.
9. Services and/or materials not indicated on the Schedule as covered Plan benefits.

EXCLUSION AND LIMITATIONS

When a covered person selects any of the following extras, the plan will pay the basic cost of the allowed lenses and the covered person will pay the additional costs.

1. Optional cosmetic processes.
2. Anti-reflective coating.
3. Color coating, Mirror coating or Scratch coating.
4. Blended, cosmetic, laminated, oversize or polycarbonate lenses.
5. Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
6. Progressive multifocal lenses.
7. UV (ultraviolet) protected lenses.
8. A frame that costs more than the Plan allowance.
9. Contact lenses (except as noted elsewhere herein).
10. Certain limitations on low vision care.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM

When you use the services of an in-network vision provider, you should pay the provider for your appropriate copay along with any services you purchased that are not covered by the Vision Plan. The provider will typically send the remainder of their bill directly to the Vision Network for reimbursement.

If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but **within 6 months** of the date of service, submit the bill to the Vision Care Plan (whose name and address are listed on the Quick Reference Chart in the front of this section of the handbook). You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits.

Vision claims submitted beyond 6 months of the date of service may not be considered for reimbursement.

Reimbursement for services provided by or obtained from a non-network vision provider will be the lesser of the actual amount charged or the Allowed Charges fees or the amount listed in the Schedule of Vision Benefits under the column titled "Non-Network Provider." Your appeal of any denied vision claims should also be submitted to the Vision Care Plan.

CLAIMS AND APPEAL INFORMATION

OVERVIEW

This chapter describes the procedures for filing claims for certain benefits under this Plan and for appealing adverse benefit determinations in connection with those claims. Claims covered by these procedures include those claims filed under the Medical Plan including the Prescription Drug Program, and Dental Plan. For claims administration and appeals process under the insured Vision Plan, Life Insurance AD&D Insurance, Disability, contact those insurance companies for information.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This chapter also discusses the process the Plan undertakes on certain appealed claims, to consult with a Health Care Professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary, is experimental or investigational).

HOW BENEFITS ARE PAID

Payment of Eligible Benefits in General: All Plan Benefits are considered for payment on the receipt of a **written** proof of claim (itemized bill from the provider of services). Sometimes additional information or records is also needed.

TIME LIMIT FOR FILING CLAIMS

All claims must be submitted to the Plan within ONE YEAR from the date of service.

No Plan benefits will be paid for any claim submitted after this period.

Claims When Using PPO Providers: If eligible services are provided through one of the Plan's Preferred Provider Organizations (PPO), the PPO Health Care Provider will submit the claim directly to the Plan instead of sending the bill to the plan participant. The Plan will then pay the PPO provider directly. PPO Providers should **not**:

a. require you to submit (at the time the service is rendered) any money other than the copay, if one applies. Any required coinsurance or deductible should be billed to you by the provider AFTER the PPO provider has received payment from the Plan. Also your portion of the coinsurance should be based on the allowed amount to the PPO provider and not the total billed charges (unless such amounts are the same);

b. send the initial bill for services to you. Instead they are to bill the plan directly by sending the initial claim to the Benefits Claims Administrator.

If a PPO provider is not adhering to the above claim/fee submission guidelines, contact the Employee Benefits Administration Office for assistance. If however, you pay a PPO Provider an amount in excess of any required copay (at the time service is rendered) and subsequently want to be reimbursed, you may not seek reimbursement from the Plan. Instead, you must discuss and obtain your reimbursement from the PPO provider directly.

Claims When Using Non-PPO Providers: Non-PPO providers are able to send their claim either to the Plan or directly to you. If the provider sends the claim to you, will need to forward the claim to the Benefits Claims Administrator. They may also require you to pay (at the time service is rendered) all or part of the charge for the services they provide. Once the non-PPO provider is paid the Allowed or Contracted Charge amount under this Plan, they may also bill you for any difference between their originally billed charges and the amount allowable by the Plan, commonly called balance billing.

For a non-PPO provider claim to be considered for processing, the claim must list the following information:

- A description of the services or supplies provided using proper coding techniques.
- Details of the charges for those services or supplies.
- Diagnosis code(s).
- Date(s) and location where the services or supplies were provided.
- Patient's name, social security or ID number, address and date of birth.
- Member or Subscriber's name, health insurance ID number and date of birth.
- Provider's name, address, phone number, professional degree or license, federal tax identification number and appropriate provider identifier number.

If a claim is submitted without the above required information and all data elements are not provided, this plan cannot consider that claim for payment under the Plan.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Note: If **you** pay a non-PPO provider for services **and then** submit the claim to the Benefits Claims Administrator for reimbursement to you, the Plan will send you reimbursement for eligible medical or dental expenses, subject to Allowed or Contracted Charges fees. A receipt indicating payment must be submitted along with the claim in order for you to receive the reimbursement check. Payments in excess of $500 may be sent to the provider if, upon verification with the provider, it is determined that you have not made payment to that provider.

Assignment of Benefits: This is a method under which the plan participant requests that benefits for a claim be paid to some person or institution, usually a physician or hospital. This provision applies to Non-PPO providers only. The permission for assignment of benefits must be sent to the Employee Benefits Administration office.

What You Must Pay Each Year: As a reminder, when Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of these charges as outlined in the Schedule of Medical or Dental Benefits.

Qualified Medical Child Support Orders (QMCSOs): A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan Benefits on account of expenses incurred by or on behalf of the Dependent Child(ren) covered by the Plan either to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan Benefits on account of expenses incurred by or on behalf of the Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document.

When You Must Repay Plan Benefits: If it is found that the Plan Benefits paid by the Plan are too much because:

a. some or all of the eligible expenses were not paid or payable by you or your covered Dependent; or

b. you or your covered Dependent received the money to pay some or all of those eligible expenses from a source other than the Plan; or

c. the Plan erroneously paid Benefits to which you were not entitled under the terms and provisions of the Plan,

then the Plan will be entitled to a refund from you or your Health Care Provider of the difference between the amount of Plan Benefits actually paid by the Plan for those expenses and the amount of Plan Benefits that should have been paid by the Plan for those expenses based on the actual facts.

ADDITIONAL INFORMATION NEEDED

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby.

KEY DEFINITIONS

Days: For the purpose of the claim and appeal procedures outlined in this chapter, "days" refers to calendar days, not business days.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, pre-existing condition exclusion, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an

item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

- a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter. There are **four types of claims** covered by the procedures in this chapter: **Pre-service, Urgent, Concurrent, and Post-service**, described later in this chapter. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a. be written or electronically submitted (oral communication is acceptable only for urgent care claims),
b. be received by the Appropriate Claims Administrator as that term is defined in this chapter;
c. name a specific individual including their social security number or Medicare HICN number,
d. name a specific medical condition or symptom,
e. name a specific treatment, service or product for which approval or payment is requested,
f. made in accordance with the Plan's benefit claims filing procedures described in this chapter; and
g. includes all information required by the Plan and it's Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits.

A claim is NOT:

a. a request made by **someone other than** the individual or his/her authorized representative;
b. a request made by a **person who will not identify him/herself** (anonymous);
c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
f. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
g. a **submission of a prescription** with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail order service.

Appropriate Claims Administrator: means the companies/organizations and types of claims outlined in the chart below. (See the Quick Reference Chart in this document for the contact information for these Appropriate Claims Administrators)

Appropriate Claims Administrator	Types of Claims Processed
Benefits Claims Administrator	• Medical post-service claims. • Dental post-service claims.
Utilization Management Company	• Urgent, Concurrent and Pre-service claims
Prescription Drug Program	• Pre-service drugs as described in the Drug row of the Schedule of Medical Benefits. • Post-service claims for out of network retail drugs as noted in the Drug row of the Schedule of Medical Benefits.

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and the Drug row of the Schedule of Medical Benefits in this document.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient's life or health.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification:

- could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, or
- in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and the Drug row of the Schedule of Medical Benefits in this document.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive concurrent care review are listed in the Utilization Management chapter in this document.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Tolled: Means stopped or suspended, particularly as it refers to timeperiods during the claims process.

Independent Review Organization or IRO: means an entity that conducts independent external reviews of adverse benefit determinations in accordance with the Plan's external review provisions and current federal external review regulations.

IF ADDITIONAL INFORMATION IS NEEDED

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable only if the Plan approves payment **before** you receive the services. The requests for these benefits are referred to as pre-service claims, also known as preauthorization or precertification. (see the definition of pre-service claims in the Definitions section). You are not required to obtain approval in advance for emergency care including care provided in a hospital emergency room, or hospital admission for delivery of a baby. Services you are required to get advance plan approval for include:

- Bariatric (weight management) surgery
- Behavioral health admissions (including day treatment, partial day care, intensive outpatient and residential treatment center services
- Day-treatment rehabilitation facility or program
- Durable medical equipment over $1,000
- Elective hospital admissions
- Elective specialized health care facility admissions (including outpatient urgery in a free-standing or hospital-based surgery center/facility, hospice, subacute care, and skilled nursing facility)
- Endoscopy services
- Genetic testing services
- Genetic counseling, evaluation and testing for BRCA
- Home health services
- Home infusion therapy services
- Hospice services
- Hospital admissions longer than 48 hours for a vaginal delivery and 96 hours for a C-section
- Inpatient rehabilitation admission
- Medications including Gleevac; Cox II inhibitors like Celebrex, Retin-A after age 35; migraine medications; weight reduction medications; and self-injectable medications like Betaseron, growth hormone, interferon, multiple sclerosis drugs
- Speech therapy treatment
- Surgical or invasive procedures performed in a physician's office estimated to cost $500 or more.
- Transplantation services

REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS PLAN

A Plan participant may request review of an issue (that is not a claim as defined in this plan) by writing to the Plan Administrator whose contact information is listed on the quick reference chart in this document. The request will be reviewed and the participant will be advised of the decision within 60 days of the receipt of the request.

AUTHORIZED REPRESENTATIVE

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in **writing** as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan. An authorized representative under this Plan may also be a health care professional. The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form, available from the appropriate claims administrator.

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g*. notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

HOW TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

A claim for post-service benefits is a request for Plan benefits made by you or your authorized representative, in accordance with the Plan's claims procedures, described in this plan. See also the "Definitions" section of this plan for a definition of a "claim" and the information on what is and is not considered a claim.

1. Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required. The appropriate claims administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
2. Generally, Plan benefits for a hospital or health care facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider.
3. Occasionally a health care provider will send a claim directly to you. In this case you should forward the claim to the aBenefits Office whose contact information is listed on the quick reference chart in this document for processing.
    - Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Benefits Office.** This can reduce costs to you and the Plan.
    - If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
    - Mail or bring the provider's actual claim to the Benefits Claim Administrator.
4. In all instances, when deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.
5. The Benefits Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.
    - This 30-day period may be extended one time for up to 15 additional calendar days if the Benefits Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.

- The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
- (If a period of time is extended due to failure to submit information, the time period is suspended ("tolled") from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
- The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

6. Before the Plan issues an adverse benefit determination, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

7. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) in addition to the Explanation of Benefits or EOB form. This notice of initial denial will:
   - **identify the claim involv**ed (e.g. date of service, health care provider, claim amount if applicable, diagnosis and treatment codes and meanings of the codes);
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - disclose the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.

8. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Plan Administrator for the first level of appeal review and to the Employee Benefits Advisory Committee for the second level appeal review, both of whom have their contact information listed on the quick reference chart in this document. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate plan fiduciary will:

- consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's 2 level appeal process, the Plan routes the first level of review to the Plan Administrator who will make the first level determination on the post-service appeal no later than 30 calendar days from receipt of the appeal.
   - There is **no extension permitted** in the first or second level of the appeal review process.
   - You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
   - If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Employee Benefits Advisory Committee whose contact information is listed on the quick reference chart in this document.
   - The Employee Benefits Advisory Committee then will make a second level determination no later than 30 calendar days from receipt of the second level appeal.
2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
4. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

   In the notice of first level appeal review determination, the notice will describe the process to proceed to a second level appeal review and timeframes if still dissatisfied with the determination.
5. This concludes the post-service appeal process under this Plan. This Plan does not offer a voluntary appeal process.

HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves urgent care (as defined earlier in this chapter), you may file the claim or the Plan will honor a health care professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

1. Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the Appropriate Claims Administrator (Utilization Management Company, Prescription Benefit Program) whose contact information is listed on the quick reference chart in this document.
2. In the case of an urgent care claim, if a health care professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.
3. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** (*effective on or after 1-1-2012 this time period becomes 24 hours)* after receipt of an urgent care claim by the utilization management company, or prescription drug program. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

4. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the utilization management company or prescription drug program, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours (*effective on or after 1-1-2012 this time period becomes 24 hours)* after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

5. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

6. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
   - you will be provided a description of the expedited appeal review process for urgent care claims.

7. **If you disagree with a denial of an urgent care claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program), whose contact information is listed on the quick reference chart in this document.

2. You will be provided with:
   - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate plan fiduciary will:
     - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.

4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;

- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

5. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer a voluntary appeal process.

HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves concurrent care (as that term is defined earlier in this chapter), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program) whose contact information is listed on the Quick Reference Chart in this document.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

2. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this chapter.

3. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this chapter.

4. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

5. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

6. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program), whose contact information is listed on the Quick Reference Chart in this document.

2. You will be provided with:
   - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate plan fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.

4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

5. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer a voluntary appeal process.

HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with this Plan's claims procedures outlined in this chapter.

2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management chapter and Drug row of the Schedule of Medical Benefits of this document) to the Appropriate Claims Administrator (as defined in this chapter).

3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.

4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, and the Appropriate Claims Administrator notifies you prior to the expiration of the initial 15-day period by using a written notice of extension.

5. If a period of time is extended due to failure to submit information, the time period is suspended ("tolled') from the date on which the notice of extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the notice was sent to you.

6. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.

7. In either case noted above, you will be notified of the need for additional information in the notice of extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the notice of extension on which a decision will be made if no additional information is received.

9. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).

10. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    - give the specific reason(s) for the denial;
    - reference the specific Plan provision(s) on which the determination is based;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's appeal procedure along with time limits;
    - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
    - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

11. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Plan Administrator for the first level of appeal review and to the Employee Benefits Advisory Committee for the second level appeal review, both of whom have their contact information listed on the quick reference chart in this document. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's 2 level appeal process, the Plan routes the first level of review to the Plan Administrator who will make the first level determination on the pre-service appeal no later than 15 calendar days from receipt of the appeal.

2. There is **no extension permitted** to the Plan in the first or second level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

3. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Employee Benefits Advisory Committee, whose contact information is listed on the quick reference chart in this document.

4. A second level determination will be made no later than 15 calendar days from receipt of the second level appeal.

5. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.

6. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

7. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

   In the notice of first level appeal review determination, the notice will describe the process to proceed to a second level appeal review and timeframes if still dissatisfied with the determination.

8. This concludes the pre-service appeal process under this Plan. This Plan does not offer a voluntary appeal process.

OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours *(24 hours effective on or after 1-1-2012)*	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each level	30 days for each level
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days of receipt of the first level appeal determination	180 days of receipt of the first level appeal determination
Extension permitted during appeal review?	No	No	No	No

[1]: no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements as set forth in Interim Final Regulations implementing the ACA and in Technical Release 2010-01. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

If your appeal of a claim, whether urgent, concurrent, pre-service or post-service claim is denied, you may request further review by an independent review organization ("IRO") as described below. Generally, you may only request external review after you have exhausted the internal review and appeals process described above.

This external review process does not pertain to claims for the insured vision plan benefits, life/death benefits, AD&D, disability, the Plan's health flexible spending account (FSA) or if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

1. **External Review of Standard (Non-Urgent) Claims**.

   Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an initial claim benefit determination or adverse appeal claim benefit determination. For convenience, these determinations are referred to below as an "adverse determination," unless it is necessary to address them separately.

   Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for appeal claim benefit determinations.

   An external review request on a standard claim should be made to the following applicable **Plan designee**:

   - The Medical Plan Benefits Claims Administrator ("Plan Administrator"), with respect to a denied medical plan claim not involving retail or mail order prescription drug expenses;
   - The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;
   - The Utilization Management Program provider, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses or behavioral health expenses;

   Contact information for the Medical Plan Benefits Claims Administrator ("Plan Administrator"), the Prescription Drug Program provider, and the Utilization Management Program provider is identified in the Quick Reference Chart, as amended from time to time.

   A. **Preliminary Review of Standard Claims**.

      1. Within five (5) business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:

         (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

         (b) The adverse determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

         (c) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

         (d) You have provided all of the information and forms required to process an external review.

      2. Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

         (a) If your request is complete and eligible for external review; or

         (b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

         (c) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

   B. **Review of Standard Claims by an Independent Review Organization (IRO)**.

      1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its adverse determination.

c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its adverse determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

e. The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.

f. The assigned IRO's decision notice will contain:

1.) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

2.) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

3.) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

4.) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

5.) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

6.) A statement that judicial review may be available to you; and

7.) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

2. **External Review of Expedited Urgent Care Claims**.

A. You may request an expedited external review if:

(a) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

(b) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would

jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Your request for an expedited external review of a non-standard claim should be made to the following applicable **Plan designee**:

- The Utilization Management Program provider, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving retail or mail order prescription drug expenses or behavioral health expenses;
- The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;

Contact information for the Utilization Management Program provider and the Prescription Drug Program is identified in the Quick Reference Chart, as amended from time to time.

B. **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

C. **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (such as via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(a) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

(b) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

3. **Overview of the Timeframes During the Federal External Review Process**.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
• Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
• When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's adverse benefit determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by you**, or until 60 days have elapsed since you filed a request for appeal review if you have not received a decision. No lawsuit may be started more than three years after the time proof of claim must be given.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

IF YOU NEED ASSISTANCE WITH THIS PROCESS

If you have questions about this process or need assistance, you can contact the following:

Arizona Department of Insurance

Consumer Services

2910 N. 44th Street, Ste. 210

Phoenix, AZ 85018-7269

Phoenix: (602) 364-2499

Spanish: (602) 364-2977

Toll free: (800) 325-2548

http://www.id.state.az.us/

consumers@azinsurance.gov

COORDINATION OF BENEFITS (COB)

HOW COORDINATION OF BENEFITS OCCURS

This chapter describes the circumstances when you or your covered Dependents may be entitled to medical (including Behavioral Health), dental and/or prescription benefits under this Plan and may also be entitled to recover all or part of these expenses from some other source. It also describes the rules that apply when this happens. There are several circumstances that may result in you and/or your covered Dependents being reimbursed for your healthcare expenses not only from this Plan but also from some other source. This can occur if you or a covered Dependent is also covered by:

1. Another group health care plan; or
2. Medicare or some other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
3. Workers' compensation.

Duplicate recovery of healthcare expenses can also occur if a third party is financially responsible for these expenses because that third party caused the injury or illness giving rise to those expenses by negligent or intentionally wrongful action.

This Plan operates under rules that prevent it from paying Benefits which, together with the benefits from any other source described in the above paragraphs, would allow you to recover more than 100% of eligible expenses you incur. In many instances, you may recover less than 100% of those eligible expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource.

COORDINATION OF BENEFITS (COB): COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies: For the purposes of this Coordination of Benefits section, the word "plan" refers to any group medical, dental, prescription drug or Behavioral Health policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of services incurred by the covered person or that provides services to the covered person. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. Many families that have more than one family member working outside the home are covered by more than one health plan. If this is the case with your family, **you must let this Plan (or its insurer) know about all your coverages when you submit a claim.**

Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the expenses incurred.** Sometimes, the combined benefits that are paid will be **less than** the total expenses.

- **NOTE: The City of Mesa Health Plan does not coordinate benefits with plans in which the claimant's responsibility is a copayment.**

WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.** If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

A. **Rule 1: Non-Dependent/Dependent**
   1. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.
   2. There is one exception to this rule: As a result of the provisions of Title XVIII of the Social Security Act and implementing Medicare regulations, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as **other than** a dependent, for example:
      a. Active Employees and Dependents: Both the employee and dependent can waive Medicare coverage but if it is not waived, Medicare is secondary for both employee and dependent if eligible.
      b. Retirees and Dependents: Must have enrolled in Medicare if eligible to remain on the City of Mesa Plan. Medicare is primary.

B. **Rule 2: Dependent Child Covered Under More Than One Plan**

1. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if the parents are married; the parents are not separated (whether or not they ever have been married); or a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
2. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.
3. The word "**Birthday"** refers only to the month and day in a calendar year; not the year in which the person was born.
4. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does **not** apply during any Plan Year during which any Benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.
5. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
   - The plan of the custodial parent pays first;
   - The plan of the spouse of the custodial parent pays second; and
   - The plan of the non-custodial parent pays third; and
   - The plan of the spouse of the non-custodial parent pays last.

C. **Rule 3: Active/Laid-Off or Retired Employee**

1. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

D. **Rule 4: Continuation Coverage**

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

1. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
2. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

E. **Rule 5: Longer/Shorter Length of Coverage**

1. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
2. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
3. The start of a new plan does **not** include a change:
   - in the amount or scope of a plan's benefits;
   - in the entity that pays, provides or administers the plan; or
   - from one type of plan to another (such as from a single employer plan to a multiple employer plan).

F. **Rule 6: Medicaid and Tricare**

1. Other non-Medicare governmental programs pay last.

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of "Allowable Expenses" **less** whatever payments were actually made by the plan (or plans) that paid first, after the applicable deductible has been met. In addition, when this Plan pays second, it will never pay more in Benefits than it would have paid during the Plan Year (for each claim as it is submitted) had it been the plan that paid first.

1. "**Allowable Expense"** means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:
   - The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
   - If the coordinating plans determine Benefits on the basis of Allowable Charges, any amount in excess of the highest Allowable Charge is not an Allowable Expense.
   - If the coordinating plans provide Benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
   - If one coordinating plan determines Benefits on the basis of Allowable Charges and the other coordinating plan provides Benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.
   - When benefits are reduced by a primary plan because a covered person did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.
2. Allowable Expenses **do not** include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

ADMINISTRATION OF COB

To administer COB, the Plan reserves the right to:
1. exchange information with other plans involved in paying claims;
2. require that you or your Health Care Provider furnish any necessary information;
3. reimburse any plan that made payments this Plan should have made; or
4. recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, this Plan will pay secondary medical benefits **only** when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits. This Plan will not pay secondary medical benefits on a claim when the coordinating primary plan paid dental benefits on that claim, nor will this Plan pay secondary dental benefits on a claim when the coordinating primary plan paid medical benefits on the claim.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan. If this Plan is secondary, and if the coordinating primary plan does **not** cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan only to the extent they would have been payable if this Plan were the primary plan.

Benefit Reserve: Effective 1/1/08, this Plan does not administer a benefit reserve (also called a benefit bank, credit balance, credit reserve or credit savings) calculation in the coordination of benefits.

MEDICARE

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If your covered Spouse or Dependent Child becomes covered by Medicare, either because of disability or age, you may either retain or cancel your coverage under this Plan. If your Spouse and/or your Dependent Child are covered by this Plan and by Medicare, and they retain coverage

under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same benefits and your contributions for coverage will remain the same, and this Plan pays first and Medicare pays second.

Medicare and Total Disability: If you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the chapter on COBRA for more information. However, if you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

Medicare and ESRD: If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

When the Plan Participant Is Covered by Medicare Advantage (formerly called Medicare + Choice or Part C): This Plan does not coordinate with Medicare Advantage plans.

Medicare and Medicare Private Contracts: Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners. A Medicare private contract must be in writing and it states that neither the health care practitioner nor the Medicare participant can submit claims to Medicare for services furnished by that practitioner. When such a contract exists, Medicare will not pay any benefits for any services or supplies provided by that practitioner. If a Medicare participant enters into such a contract this Plan will pay normal plan benefits for eligible services as if the participant used a non-Medicare contracted provider.

When Covered by this Plan and also by a Medicare Part D Plan such as a Prescription Drug Plan: If you have dual coverage under both this Plan and Medicare Part D, this Plan will not coordinate that dual coverage. **You will be disenrolled from the prescription drug coverage under this Plan while you are enrolled in a Medicare Part D plan.**

Medicaid: If a covered individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

TRICARE: If a covered individual is covered by both this Plan and TRICARE (formerly known as CHAMPUS), this Plan pays first and TRICARE pays second.

Veterans Affairs/Military Medical Facility Services: If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a **military service-related illness or injury**, benefits are **not** payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed or Contracted Charges.

Motor Vehicle No-Fault Coverage Required by Law: If a covered individual is covered for medical, dental, prescription drug or behavioral health benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Workers' Compensation: This Plan does **not** provide benefits if the healthcare expenses are covered by workers' compensation or occupational disease law. If the City contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law.

Subrogation: There is no subrogation provision under this Plan.

COBRA CONTINUATION OF COVERAGE

CONTINUATION OF COVERAGE IN GENERAL

Except with respect to certain dental services described in the Dental Plan Benefits chapter of this document, your Plan does **not** provide for an extension of Plan benefits for any services or expenses incurred **after** coverage ends. However, under certain circumstances your medical, dental, prescription and vision coverages may be continued for a limited period of time. This chapter explains when and how this continuation of coverage occurs. Continuation of coverage applies only to medical, dental, prescription drug and vision coverages and does **not** apply to life insurance, accidental death and dismemberment, long-term disability or other income replacement coverages.

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law commonly called COBRA, this Plan offers its employees and their covered Dependents (called **"Qualified Beneficiaries"** by the law) the opportunity to elect a temporary continuation (**"COBRA Continuation Coverage"**) of the group health coverage sponsored by the City, including medical, dental, prescription drug, vision coverages, and the health care flexible spending account (the **"Plan"**), when that coverage would otherwise end because of certain events (called **"Qualifying Events"** by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This notice is provided to all covered Employees and their Covered Spouses, and is intended to inform them (and their covered Dependents, if any) in a summary fashion of their rights and obligations under the continuation coverage provisions of the law. Since this is only a summary, their actual rights will be governed by the provisions of the COBRA law itself.
Note: It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

COBRA Administrator

The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

Who Is Entitled to COBRA Continuation Coverage; When (the Qualifying Event); and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A qualified beneficiary also has the same rights under the Plan as other covered individuals including Open and Special enrollment.

1. **"Qualified Beneficiary":** Under the law, a Qualified Beneficiary is any Employee, his or her Spouse or Dependent Child who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new spouse of an employee during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.
2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a qualifying event but does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not yet offered.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law, as noted below:

a. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and
b. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. A person may also become entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Dependent Child ceases to have Dependent status	N/A	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the City files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Life	Varies[2]	Varies[2]

1: When a covered employee's qualifying event (i.e. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered spouse and dependent children who are qualified beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

2: Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain retirees and their related qualified beneficiaries such as COBRA coverage for the life of the retiree. The retiree's spouse and dependent children are entitled to COBRA for the life of the retiree and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's surviving spouse is alive and covered by the group health plan, then that surviving spouse is entitled to coverage for life.

Procedure on When the Plan Must Be Notified of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, you and/or a family member **must inform the Plan in writing of that event no later than 60 days after that event occurs.**

The written notice should be sent via first class mail or hand-delivered to the COBRA Administrator (whose address is listed on the Quick Reference Chart in the front of this document) and is to include your name, the qualifying event, the date of the qualifying event and appropriate documentation in support of the qualifying event such as divorce documents.

NOTE: If such a notice is not received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Other City officials or employees will usually notify the COBRA Administrator of the employee's death, termination of employment, reduction in hours. However, you or your family **should also notify** the COBRA Administrator promptly of these changes as well as any entitlement to Medicare in writing to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage.

Note: Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.

Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA Coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this subchapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

When COBRA continuation coverage of your participation in the health care flexible spending account is available, it will be on the same terms outlined above for group health coverage, but since the person who elects it will not be employed by the City, **it will not be possible** to make contributions to the health care flexible spending account on a **before-tax** basis.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The City is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the City's and employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. Under this Plan, after the initial COBRA payment, subsequent payments are **due on the fifteenth (15th) of the prior month, but there will be a 45-day grace period to make those payments**. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been

received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but the COBRA Administrator determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

1. If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, **the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours** (or the date you first became entitled to Medicare, if that is earlier, as described below). Medicare entitlement is not a qualifying event under the Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.

2. **Notifying the Plan**: To extend COBRA when a second qualifying event occurs, you must notify the COBRA Administrator in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. For information on how to notify the Plan, see the subsection in this chapter entitled "Procedure on When the Plan Must be Notified of a Qualifying Event."

3. **This extended period of COBRA Continuation Coverage is <u>not</u> available to anyone who became your Spouse after the termination of employment or reduction in hours**. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you during the 18-month period of COBRA Continuation Coverage.

4. In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination if employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

5. In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months except for retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of the City.

Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

1. If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).
2. **This extension is available only** if:
   - the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
   - **Notifying the Plan:** you or another family member follow this procedure to notify the Plan by sending a written notification to the COBRA Administrator of the Social Security Administration determination **within 60 days after that determination was received by you** or another covered family member (failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage). For information on how to notify the Plan see the subsection in this chapter entitled "Procedure on When the Plan Must be Notified of a Qualifying Event"; **and**
   - that notice is received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.
3. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be much higher for the disabled individual than the cost for that coverage during the 18-month period.
4. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are not longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of **any** of the following events:

1. The date on which the City no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date the lifetime benefit maximum is exhausted on all benefits;
5. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have;
6. The date the plan has determined that the covered person must be terminated from the plan for cause.
7. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

COBRA Questions or To Give Notice of Changes in Your Circumstance

If you have any questions about your COBRA rights, please contact the COBRA Administrator located in the Employee Benefits Administration Office.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you <u>must</u> notify the COBRA Administrator:

1. within 31 days of a **change in marital status (e.g. marry, divorce)**; or have **a new dependent child**; or

2. within 60 days of the date you or a covered dependent spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, become entitled to Medicare, or is no longer disabled**.

BRIEF OUTLINE ON HOW CERTAIN LAWS INTERACT WITH COBRA

FMLA and COBRA

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the qualifying event, in most cases, the last day of the FMLA leave. Note that if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA

If an employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18, 29, or 36 month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

1. When your COBRA coverage ends, the COBRA Administrator will automatically provide you and/or your covered Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If, within 62 days after your coverage under this Plan ends, you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.
2. The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. If you (or any of your covered Dependents) elect COBRA Continuation Coverage, another certificate will be sent to you (or if COBRA Continuation Coverage is provided only to your covered Dependent(s) then to them), by first class mail shortly after the COBRA Continuation Coverage ends for any reason.
3. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a request for such a certificate if that request is received by the COBRA Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to the COBRA Administrator in care of the Employee Benefits Administration Office at the address listed on the Quick Reference Chart in the front of this document. See the Eligibility chapter for the procedure for requesting a certificate of coverage.

GENERAL INFORMATION

NAME OF THE PLAN: The City of Mesa Health Plan

EMPLOYER IDENTIFICATION NUMBER: 86-6000252

TYPE OF ADMINISTRATION:

The City of Mesa offers a variety of benefits to employees and retirees and eligible dependents. Some of the benefits offered are contractual arrangements with insurance vendors such as the vision plan, EAP, child care resource and referral, elder care resource and referral, life insurance, commuter death benefits, short term disability and long term disability. Refer to the Quick Reference Chart in the Introduction chapter of this document for the names of any insurance companies administering these benefits.

Other services are self-insured by the City, including the Medical and Dental plan options, and the flexible spending accounts. Further, the City self-administers some of the self-insured benefits, including claims for the medical and dental plan options and the flexible spending account.

The City of Mesa has contracted with a stop-loss reinsurance company to provide stop-loss reinsurance to the self-insured portions of the medical benefit plan that will reimburse the Plan for certain losses in excess of amounts described in the stop-loss insurance policy. Under this policy, there is no guarantee, and no obligation to pay any Plan Benefits or to make any other payments to any Plan Participant. Contact the Employee Benefits Administration Office for the name of the stop loss carrier.

PLAN ADMINISTRATOR:

The City of Mesa Employee Benefits Administrator is the Plan Administrator. The Plan Administrator is located in the Employee Benefits Administration Office whose address is listed in the Quick Reference Chart in the Introduction chapter of this document.

CLAIMS REVIEW FIDUCIARY:

With respect to all matters regarding eligibility, Medical claims, general benefits information, Dental claims, and Flexible Spending Accounts, contact the Employee Benefits Administration Office whose address is listed in the Quick Reference Chart in the front of this document.

AGENT FOR SERVICE OF LEGAL PROCESS:

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator.

THIS IS NOT AN ERISA PLAN:

This Plan is <u>not</u> subject to the provision of the Employee Retirement Income Security Act of 1974 (ERISA) and participants are <u>not</u> entitled to certain rights and protections under (ERISA).

PLAN AMENDMENTS OR TERMINATION OF PLAN:

The City of Mesa reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be made by writing to the Plan Administrator and become effective on the written recommendation of the Employee Benefits Advisory Committee and approval of the Mesa City Council, or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the City Council and new coverages may be added by the City Council.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES:

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF THE CITY'S RIGHTS:

The City of Mesa makes no representation that employment with it represents lifetime security or a guarantee of continued employment. An individual's employment may be terminated because of:

1. unsatisfactory job performance;
2. unsatisfactory attendance;
3. violation of the City's rules and policies; or
4. because an individual's services become excess to the City's staffing needs.

An individual's employment may also be terminated whenever the City, in its sole judgment, deems that to be in its best interest. The City, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of participants, as defined by law. Any written or oral statement other than a written statement signed by the City Manager that is contrary to the provisions of this section **is invalid**, and no prospective, active or former employee should rely on any such statement.

NO LIABILITY FOR PRACTICE OF MEDICINE:

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that health plans like the City of Mesa Health Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by the City of Mesa in its role as an employer, including but not limited to health information related to disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you or distributed to you upon enrollment in the Plan and is also available from the Employee Benefits Office or via our website www.mesachip.mesaaz.gov. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the City of Mesa), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.
   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
     a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
     b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, , billing, collection activities and related health care data processing, and claims auditing;
     c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:
  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment,
  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
  c. Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers, and resolution of internal grievances.

B. **When an Authorization Form is Needed**: Generally the Plan will require that you sign a valid authorization form (available from the City of Mesa Employee Benefits Administration Office or online at www.mesachip.mesaaz.gov) in order for the Plan to use or disclosure your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations. The Plan's Privacy Notice also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:
  1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
  2. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
  3. Not use or disclose the information for employment-related actions and decisions,
  4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
  5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
  6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
  7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
  8. Make available the information required to provide an accounting of PHI disclosures,
  9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
  10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

D. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and/or disclose PHI:
  1. The Plan Administrator,
  2. Employees of the City of Mesa Employee Benefits Administration Unit.
  3. Staff designated by the Plan Administrator, such as Payroll staff, certain other City staff who provide financial, technological, and administrative support and assistance, and the Employee Benefits Advisory Committee for grievances.
  4. Business Associates under contract to the Plan including but not limited to the medical plan preferred provider organization network, utilization review/case management firm, prescription benefit manager and subsidiary firms, vision plan administrator, and employee assistance program administrator.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

F. **Effective April 21, 2005 in compliance with HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN (Very Important Information):

In addition to information you must furnish in support of any claim for Plan Benefits under this Plan, you or your covered Dependents must furnish, within **30 days** after the event, any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

1. Change of name.
2. Change of address.
3. Marriage, divorce, or death of you or any covered Spouse or Dependent Child.
4. Any information regarding the status of a Dependent Child, including, but not limited to:
   - The Dependent Child reaching the Plan's limiting age; or
   - The existence of any physical or mental Disability or the fact that a disability no longer exists.
5. Medicare enrollment or disenrollment.
6. The existence of other medical or dental coverage.

Notices of the foregoing information should be sent, **in writing**, to the Plan Administrator at the address shown in the Quick Reference Chart in the Introduction chapter of this document. See also the timeframes relating to Special Enrollment in the Eligibility chapter of this document.

HEADINGS DO NOT MODIFY PLAN PROVISIONS:

The headings of chapters and subchapters, sections (APPEARING IN **BOLD** TEXT WITH SOLID CAPITAL LETTERS) and paragraphs and subparagraphs (Appearing in Bold Text with Upper and Lower Case Letters) are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents and index can be constructed for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

FLEXIBLE SPENDING PLAN

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) AND DEPENDENT CARE FSA, AND EXCESS CREDITS

The Flexible Spending Plan offers you the opportunity to set aside pre-tax dollars from your paycheck to pay for either health care or dependent care expenses that would normally be paid out of your own pocket. When you enroll in and voluntarily contribute to the flexible spending account program you reduce your federal, state and social security taxes by reducing the amount of your taxable income.

The City's Flexible Spending Account (FSA) plan is an in-house program administered by the Employee Benefits Administration Office. To be eligible to participate in the FSA plan, you must complete an application form or make your election on-line via the On-Line Open Enrollment system. Your effective date in the FSA plan will be the same as your effective date in the medical plan as determined by the Employee Benefits Administration Office.

The money in your Flexible Spending Account may be used to pay for certain reimbursable medical or eligible dependent care expenses incurred during the elected calendar year after your effective date in the Plan. The portion of your salary deducted from your paycheck and applied to your FSA is **not** subject to federal or state income withholding tax, or social security tax. In other words, by contributing to the Plan, you may use tax-free dollars to pay for certain medical or dependent care expenses that you would normally pay for with out-of-pocket, taxable dollars.

NOTE: If you receive reimbursement for an expense from one of the Flexible Spending Accounts, you cannot claim that expense as a deduction, or take a federal income tax credit on your income tax return.

HEALTH FLEXIBLE SPENDING ACCOUNT

Money set aside in the Health Flexible Spending Account may be used to pay for certain reimbursable health care expenses that are not covered by your health insurance. ***NOTE: Eligible expenses may be incurred by any of your family members, whether or not they are enrolled in one of the City-sponsored health insurance plans, or if they are covered by another insurance plan.*** Expenses covered by any insurance plan, whether sponsored by the City of Mesa or any other employer must be submitted to and processed by the insurance carrier(s) before being submitted to the FSA.

OVER-THE-COUNTER MEDICINES & PRODUCTS

Beginning January 1, 2011, OTC medicines or drugs, such as pain relievers or antacids will require a physician's prescription in order to be considered eligible for reimbursement. The only exception is insulin – which will **not** require a prescription.

Over-the-counter (OTC) products that **are not** medicines or drugs are reimbursable under a Health Care Flexible Spending Account without a prescription when the OTC product is used for medical purposes. This includes items such as sunscreen, bandages, and contact lens solution.

ELIGIBLE OTC PRODUCTS

Eligible items include products that alleviate or treat injuries or illness for you and your dependents. These products are not cosmetic in nature, or merely beneficial to your general health. Claims for OTC products that are not medicines or drugs must include an adequate receipt accompanied by the Health Care FSA claim form. An adequate receipt states the name of the product, the date, and the amount paid. You do not need to provide a statement from a medical provider or indicate a diagnosis in order to receive reimbursement.

Claims for OTC medicines or drugs must include a physician's prescription, and an adequate receipt accompanied by the Health Care FSA claim form, as well as a copy of the label or packaging.

DUAL-PURPOSE PRODUCTS

Certain OTC products are considered dual-purpose, such as vitamins and supplements. That's because for some individuals, the product is used to alleviate a medical condition, while others use the product for general health and well-being. These products may be eligible for reimbursement, but require **a Letter of Medical Necessity (LMN) stating your specific diagnosis or medical condition,** a recommendation to take the specific OTC item to treat your medical condition, and documentation of the product and cost**. Please note: Submitting an LMN for your claim does not guarantee that the expense will be approved.**

Please note all "potentially eligible health care expenses" require a **letter of medical necessity** from your health care provider in order to be considered eligible for reimbursement. The letter must include the diagnosis or symptoms for which you, your spouse, dependent or adult child through age 26 are being treated, along with specific information on how the product or service is intended to alleviate symptoms or improve function. Submitting a LMN for your claim does not guarantee that the

expense will be reimbursed. You must submit a new LMN each year if the medical condition persists - they cannot be approved indefinitely.

As of January 1, 2011 currently eligible over-the-counter (OTC) products that are medicines or drugs (e.g., acne treatments, allergy and cold medicines, antacids, etc.) will **only** be eligible for reimbursement from your Health Care FSA with a physician's prescription. The only exception is insulin - which will not require a prescription. OTC products or items that are not considered medicines or drugs, such as bandages and nasal strips, will continue to be eligible without a prescription.

EXCLUDED ITEMS

OTC products that merely benefit your general health or are cosmetic in nature are NOT reimbursable. The list below indicates services and products that are either eligible or not eligible for reimbursement, including those items and/or services which may require a prescription. The list is not an all-inclusive list, so if you believe you may be eligible for reimbursement under this program, please contact the Employee Benefits Administrator for clarification.

Condition/Type of Service/Expense	Eligible	Potentially Eligible	OTC Prescription Required	Not Eligible
Abortion, illegal				X
Abortion, legal	X			
Acne medication, no lotions, cleansers or soaps			X	
Acupuncture	X			
Adoption, medical costs of adopted child	X			
Adoption, medical costs of natural mother				X
Air conditioner or furnace, as permanent improvement to property				X
Alcoholism or Drug Dependency Treatment	X			
Allergy medications, such as oral medications, nasal sprays and patches			X	
Ambulance Charges, including other travel costs to obtain medical care	X			
Analgesics, such as fever and pain reducers like aspirin			X	
Antacids			X	
Antibiotic creams/ointments			X	
Anticipated medical expenses				X
Anti-diarrhea medications			X	
Anti-fungal medications			X	
Anti-gas medications			X	
Anti-itch medications			X	
Any expenses incurred in connection with an illegal operation or treatment				X
Arthritis pain relieving creams			X	
Athlete's foot treatment, such as nail and foot anti-fungal creams			X	
Auto insurance premiums, including the segment providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.				X
Bandaids, Bandages	X			
Birth control pills	X			
Blind Persons: seeing eye dog, special education, Braille books, etc.	X			
Blood Pressure monitor		X		
Breast Pumps and Lactation Supplies	X			
Bug bite medication			X	
Burn/sunburn medications			X	
Calcium Supplements		X		
Car depreciation or insurance				X
Car: equipped to accommodate wheelchair passenger, disability controls	X			
ChapStick/lip balm				X
Childbirth classes (Lamaze) for the mother	X			
Chiropractor fees	X			
Christian Science treatment; Native American medicine man	X			
Cleansers or soap that are considered toiletries (non-medicated)				X
Cold and flu medications such as tablets, syrups, drops and medicated throat lozenges			X	
Cold sore medicines			X	

Condition/Type of Service/Expense	Eligible	Potentially Eligible	OTC Prescription Required	Not Eligible
Contact Lens solution/supplies, including insurance – if not covered by a vision service plan	X			
Contact lenses, cleaning and soaking solutions, and lens storage cases	X			
Contraceptives, prescription	X			
Cosmetic products of any kind such as make-up, cotton swabs, baby oil				X
Cosmetic surgery unless medically necessary				X
Cosmetics, toiletries, etc.				X
Cough/cold/flu/fever reducers			X	
Counseling for treatment of medical or mental diagnosis, including psychotherapy, bereavement, grief counseling and is rendered by a licensed provider	X			
Crutches		X		
Dance lessons				X
Deaf persons: hearing aid, lip-reading expenses, notetaker, special education telephone, TV, visual alert system.	X			
Deductibles – Balance not paid by medical plan such as copayment and coinsurance	X			
Dental Fees, dentures	X			
Dental floss, mouthwashes, tooth brushes and toothpaste				X
Deodorants, soap, body powder, shaving cream and razors				X
Diabetic supplies, such as glucose monitor and related equipment		X		
Diaper rash ointments			X	
Dietary Supplements – used to improve or maintain general health				X
Doctor's Fees	X			
Drugs, formerly prescription only (i.e. Claritin and Prilosec)			X	
Dust elimination services				X
Dyslexia, language training, remedial reading	X			
Ear care/swimmer's ear-medications only not ear plugs			X	
Electrolysis		X		
Eye and facial makeup preparations				X
Eye care, such as contacts, saline solution and lubricant eye drops	X			
Eye exam and glasses – Lenses, frames & exams, eye surgery and contact lenses - if not covered by a vision service plan	X			
Face cream				X
Family planning, pregnancy tests/condoms with prescription	X			
Feminine care relating to treatment of vaginal infections			X	
Feminine hygiene – most likely used for general health or toiletries, but there could be exceptions.		X		
Fertility enhancement services	X			
Fiber supplements – used for general health				X
Fingernail polish				X
First aid creams/ointments			X	
Funeral expenses				X
Glucosamine/Chondroitin – used for arthritis		X		
Guide Dog – For blind and deaf, including cost of maintaining	X			
Hair care such as hair color, hair products and brushes				X
Hair transplants, ear piercing, tattoos				X
Halfway House – Care to help individual adjust from life in a mental hospital to community living	X			
Health club dues for specific exercise prescribed by physician for a medical condition.		X		
Health club dues, YMCA dues, steam bath, etc. not related to a medical condition				X
Hearing aid batteries		X		

Condition/Type of Service/Expense	Eligible	Potentially Eligible	OTC Prescription Required	Not Eligible
Hearing Aids	X			
Heartburn/indigestion medications			X	
Hemorrhoid creams/suppositories			X	
Herbal medications		X		
Herbal supplements – used to improve or maintain general health				X
Home modifications for disabled individual	X			
Hormone therapy/treatments for menopause – used to treat symptoms such as hot flashes, night sweats, etc.		X		
Hospitalization	X			
Household and domestic help				X
Household products to treat allergies		X		
Hydrogen Peroxide			X	
Insurance premiums paid on an after-tax basis—for hospitalization or medical coverage by a spouse or dependent under their employer's plan				X
Laboratory Fees	X			
Laetrile – If legally qualified as a drug where purchased	X			
Laxatives			X	
Lifetime Care – Advance payment to private institution for lifetime care, treatment or training of mentally or physically disabled patient.	X			
Lipstick				X
Lodging expenses for care not provided in hospital or equivalent outpatient facility				X
Long Term Care services.	X			
Marriage counseling, Life coaching, career counseling				X
Maternity clothes, diaper services, etc.				X
Medical Marijuana, regardless of medical necessity or prescription				X
Medicated shampoo for psoriasis and lice			X	
Medicated shampoos/Medicated soaps – only if physician diagnoses skin or scalp infection and prescribes special treatment to be applied for limited period of time.		X		
Medicines – Legally obtained prescription drugs for treatment of illness or injury. Certain IRS-approved over the counter medication.	X			
Menstrual cramp/pain medications			X	
Motion sickness such as tablets and patches			X	
Mouthwash				X
Nasal decongestants			X	
Nasal sprays for snoring		X		
Nausea/vomiting medications			X	
Nicotine gum			X	
Nicotine patches			X	
Nursing Home	X			
Nursing Services – By registered nurse or licensed practical nurse for medical care (other than a member of the patient's family).	X			
Nutritional and dietary supplements				X
Optometrist – Services within scope of license	X			
Orthodontia	X			
Orthopedic inserts – if medically prescribed for treatment of medical condition		X		
Orthotics, foot	X			
Over-the-counter drugs & supplies not listed as an eligible OTC expenses in this list.				X
Oxygen equipment	X			
Pain relievers/fever reducers			X	
Pain relievers-muscle pain			X	
Pedialyte for child's dehydration			X	

Condition/Type of Service/Expense	Eligible	Potentially Eligible	OTC Prescription Required	Not Eligible
Pills for lactose intolerance		X		
Pinworm medication			X	
Poison treatment			X	
Prenatal vitamins – not for general well being		X		
Prescription drugs, Insulin, diabetic supplies.	X			
Prosthetics, artificial limbs	X			
Psychiatrists, Psychologists, psychotherapists	X			
Radial Keratotomy	X			
Rashes: diaper rash/fever blisters			X	
Rashes: poison oak/ivy/sumac			X	
Routine Physical Exams	X			
Sexual dysfunction, treatment of	X			
Shampoo				X
Sinus medications			X	
Skin care such as moisturizers, sun lotion, sun block and lip balms				X
Sleep aids, such as snoring strips				X
Sleeping medication for insomnia			X	
Smoking cessation program	X			
Smoking cessation treatment		X		
Spiritual guidance				X
Sterilization, legal, vasectomy	X			
Sunscreen – only if prescribed for a specific medical condition, not for general skin health		X		
Sunscreen – used for general health purposes				X
Suntan lotion				X
Swimming pool for treatment of polio or arthritis	X			
Teeth whitening products				X
Throat lozenges-medicated			X	
Toiletries of any kind				X
Tooth and mouth pain relief such as medicated rinse			X	
Toothbrushes				X
Toothpaste				X
Transplants, including donor's costs	X			
Transportation expense to and from work, even though a physical condition may require special means of transportation.				X
Vacation or travel taken for general health or taken to relieve physical or mental discomfort not related to a particular disease or physical defect				X
Vitamins – used to improve or maintain general health				X
Vitamins– For treatment of illness (prescribed by physician)	X			
Wart removal medication			X	
Weight Loss program – amounts paid by individuals for participation in a weight-loss program as treatment for a specific disease or diseases (including obesity) diagnosed by a physician. Items that replace normal food consumption are not reimbursable (i.e. diet foods, drinks, bars). Supplements/drugs that are purchased for general dietary health are not reimbursable.		X		
Weight Loss Program if used to treat a specific disease diagnosed by a Physician (but not membership at a gym)	X			
Weight loss programs to improve appearance				X
Weight reduction aids such as food supplements				X
Wheelchair	X			
Wig, for alleviation of physical or mental discomfort	X			
X-ray fees	X			

ADDITIONAL FACTORS FOR DETERMINING ALLOWABLE EXPENSES & PREREQUISITES FOR REIMBURSEMENT OF AN OTC DRUG:

- The sponsoring plan allows for the expense.
- The OTC drug is generally regarded as a medicine or drug.
- The item is not a toiletry item or for cosmetic purposes.
- The OTC drug is legally procured.
- Expenses must be incurred during the plan year (or during the time the participant was eligible to participate).
- Expenses must be claimed using appropriate documentation. The receipt for OTC expenses must include, at a minimum, a description of the product, the date of the expense, the name of the service provider (drugstore, Dr., etc.) and the amount of the expense. Attach the receipt to an FSA claim form and send to The City of Mesa Employee Benefits office. (Keep a copy for your records.) If considered a dual-purpose item, then a note from a medical practitioner must accompany receipt.
- It is considered reasonable by the IRS, to reimburse participants who have purchased a reasonable quantity of OTC drugs to have on hand for use during the plan year, if the OTC drugs otherwise qualify as medical care. This includes year-end purchases in small quantities. Purchasing several thousand tablets of an OTC drug at year-end would be suspect. It is assumed therefore, that a few (small quantity) bottles of aspirin (for example) purchased at one time, would be eligible.

HOW TO ENROLL IN THE HEALTH FLEXIBLE SPENDING ACCOUNT

If you are a new Employee, you may enroll in the Health Flexible Spending Account Plan when you are hired. If you do not choose to enroll in the Health FSA at that time, you must wait until the Annual Open Enrollment Period to enroll for the following calendar year. All other employees may enroll in the Health FSA during the Annual Open Enrollment period for the following calendar year, or may enroll for the current calendar year if there is a Change in Status (as described below under "Change in Status" in this chapter).

The maximum amount you can deposit into a Health Flexible Spending Account is $3,000 per calendar year.

When you enroll in the plan, you must determine the total amount to be deposited into your Health FSA. This amount is then divided by the total number of pay periods expected during that calendar year, or the number of pay periods remaining in the calendar year if you join the plan after the beginning of the calendar year.

****IMPORTANT NOTICE:**** If you are thinking about enrolling in the Health FSA, you should ESTIMATE YOUR ELIGIBLE EXPENSES CAREFULLY since any money left in the account at the end of the calendar year WILL BE FORFEITED and deposited into the Employee Benefit Trust. If you are enrolling in the FSA as a new employee, only expenses that are incurred **after** your benefits effective date will be eligible for reimbursement. You need to keep that in mind when determining your annual election.

HOW TO SUBMIT HEALTH FSA CLAIMS FOR REIMBURSEMENT

After you are enrolled in the Health FSA, you may begin submitting claims for reimbursement for eligible expenses incurred during the calendar year for which you are enrolled. Claims must be submitted to the Employee Benefits Administration Office on a Health FSA Claim form, and must include documentation showing the type of expense (*e.g.*, prescription or office visit not covered under medical insurance), the date the expense was incurred, and the amount of the expense. All expenses submitted with the claim form must be itemized on the form. In some cases, a copy of the insurance Explanation of Benefits form, or original receipt will be accepted. Please refer to the Instructions for Processing FSA Claims below.

Claims submitted for reimbursement will be reviewed for eligibility and accuracy. If the claim qualifies as an eligible expense, you will receive a reimbursement check on the next scheduled pay date. Reimbursements made under the Health FSA will be equal to the amount of the claim, up to the annual elected amount, regardless of the amount deposited in your account to date. Claims may be submitted for reimbursement up to 90 days after the end of the calendar year for which you are enrolled.

ANY MONEY LEFT IN THE HEALTH FSA ACCOUNT AFTER THE 90-DAY DEADLINE WILL BE FORFEITED.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account lets you set aside money to pay for eligible child or elder care services that are needed so you and your spouse (if applicable) can work. Once you incur expenses for certain qualifying child or elder care expenses you can submit these receipts to the Plan for reimbursement from your account. The claim will be reviewed for eligibility and accuracy. Reimbursement will be made from your account equal to the amount of the claim submitted but not more than the amount currently in your Dependent Care account.

If you are married, you can enroll if you and your spouse both work or, in some situations, if your spouse goes to school full time. Single employees may also use this account to pay for eligible dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and

Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves.

Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, provided it complies with applicable state and local laws if care is provided by the facility for more than six individuals;
- An educational institution for pre-school children. For older children, only expenses for non-school care are eligible;
- An "individual" who provides care inside or outside your home who is not your child under age 19 or anyone you claim as a dependent for federal tax purposes (*i.e.*, spouse).

You should be sure that your dependent care expenses qualify under the City's Dependent Care FSA Plan. The IRS limits the amount of money that can be paid to you in a calendar year from your Dependent Care FSA. Also, in order to have the reimbursements from this account be excluded from your income, you must provide a statement from the service provider that includes their name, address, and taxpayer identification number or social security number. You may save more money by taking the Federal Child and Dependent Care Tax Credit rather than using the Dependent Care FSA.

You should ask your tax consultant for advice on which is best for you. If you decide to contribute to the Dependent Care FSA, you still need to complete and file IRS Form 2441 "Credit for Child and Dependent Care Expenses" at the end of the tax year. You will need to indicate the amount deposited in your Dependent Care FSA, which is printed in Box 10 of your Form W-2, as Dependent Care Benefits. Please contact your tax consultant or the IRS for more information.

HOW TO ENROLL IN THE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you are a new employee, you may enroll in the Dependent Care FSA when you enroll in your medical and dental plans. If you do not choose to enroll in the Dependent Care FSA at that time, you must wait until Open Enrollment to enroll for the following calendar year. All other employees may enroll in the Dependent Care FSA during the Annual Open Enrollment period for the following calendar year, or may enroll for the current calendar year if there is a Change in Status as discussed below.

The maximum amount you can deposit into a Dependent Care FSA is $5,000 per calendar year.

When you enroll in the plan, you must determine the total amount to be deposited into your Dependent Care FSA. This amount is then divided by the total number of pay periods expected during that calendar year, or the number of pay periods remaining in the calendar year (See the Example shown under "Medical Flexible Spending Accounts" above).

****IMPORTANT NOTE:**** If you are thinking about enrolling in the Dependent Care FSA, you should ESTIMATE YOUR ELIGIBLE EXPENSES CAREFULLY, since any money left in the account at the end of the calendar year WILL BE FORFEITED and deposited into the Employee Benefit Trust. If you are enrolling in the FSA as a new employee, only expenses that are incurred **after** your benefits effective date will be eligible for reimbursement. You need to keep that in mind when determining your annual election.

HOW TO SUBMIT DEPENDENT CARE FSA CLAIMS FOR REIMBURSEMENT

After you are enrolled in the Dependent Care FSA, you may begin submitting claims for reimbursement of eligible dependent care expenses incurred during the calendar year for which you are enrolled. Claims must be submitted to the Employee Benefits Administration Office on a Dependent Care FSA Claim form, and must include documentation showing the dates the day care services were rendered, the amount of the expense, the date the expense was paid, and the name, date of birth, address, and Tax Identification Number or Social Security Number of the service provider.

A sample receipt form that includes all of the required information is available in the Employee Benefits Administration Office. Please refer to the Instructions for Processing FSA Claims below.

Claims submitted for reimbursement will be reviewed for eligibility and accuracy. If the claim qualifies as an eligible expense, you will receive a reimbursement check on the next scheduled pay date. Reimbursements made from the Dependent Care FSA will be equal to the amount of the claim, but not more than the amount currently in your Dependent Care Account. Claims may be submitted for reimbursement up to 90 days after the end of the calendar year for which you are enrolled.

ANY MONEY LEFT IN THE ACCOUNT AFTER THE 90-DAY DEADLINE WILL BE FORFEITED.

ADDITIONAL INFORMATION REGARDING HEALTH AND DEPENDENT CARE

Enrollment in the Health and/or Dependent Care Flexible Spending Accounts is on a year-by-year basis. In order to continue in the program from one year to the next, you must re-enroll and re-elect your Annual Election Amount. Employees may enroll in the Plan upon becoming employed by the City, during the Open Enrollment period, or if there is a change in status (see Change in Status below).

Once you have elected to contribute to the Health and/or Dependent Care Flexible Spending Account(s), you may not change the elected amount unless there is a change in status (see below). Furthermore, the Health and Dependent Care Accounts are separate and cannot be combined, nor can funds be transferred from one account to another during the calendar year.

CHANGE IN STATUS

The only time you may open a new FSA outside of the Open Enrollment period, or may change your Annual Election Amount during the calendar year is when you have a Change in Status. The Plan Administrator, or its designee, will determine if you have a qualifying change in your status affecting your benefit needs**.** If a Change in Status occurs, you must contact the Employee Benefits Administration Office **within 30 days** of the change in order to enroll or make a change in your annual election amount. The Employee Benefits Administration Office will provide the required forms for changing the benefit elections. The following qualifying changes are **the only ones** permitted under the Plan:

1. Change in employee's legal marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;
2. Change in number of employee's Dependents, including birth, adoption, placement for adoption, or death of a Dependent Child;
3. Change in employment status or work schedule IF it impairs your, your Spouse's or your Dependent Children's eligibility for benefits, including the start or termination of employment by you, your Spouse or any Dependent Child, or an increase or decrease in hours of employment by you, your Spouse or any Dependent Child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change of work-site;
4. Change in Dependent status under the terms of this Plan that satisfies or ceases to satisfy the Plan's eligibility requirements, including changes due to attainment of age, or any other reason provided under the definition of Dependent in the Definitions chapter of this document;
5. Change of residence or worksite that allows or impairs your, your Spouse or any Dependent Child's; ability to continue benefits under the coverages you have chosen;
6. Change required under the terms of a Qualified Medical Child Support Order (QMCSO), including a change in your election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage;
7. Change consistent with your right to Special Enrollment as described in the paragraph on Loss of Other Coverage in the section dealing with Special Enrollment.
8. **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.
9. Change in cost of coverage.
    a. **Automatic increase or decrease in your contributions for coverage** under any of your employer's Health Care Plan options as a result of a change in the cost of coverage for all Plan participants, or as a result of a change in the number of your covered Dependents or a permitted mid-year change to another of your employer's Health Care Plan options, if the increase or decrease in contributions is or would be required from all similarly-situated employees. The Plan may automatically increase or decrease contributions on a reasonable and consistent basis.
    b. **Significant increase or decrease in your contributions for coverage** under your employer's Health Care Plan options or your Spouse's employer's health care plans or programs. In such a case you may start coverage in the plan option with the decreased cost; or, revoke coverage in the plan option with an increased cost and ~~either~~ elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.
10. **Significant changes in coverage.**
    a. **Significant curtailment**. If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
    b. **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

11. **Changes in Spouse's, Former Spouse's or Dependent's coverage.** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of your Spouse, Former Spouse or Dependent for one of the following reasons:
    a. If the change is permitted under federal cafeteria plan regulations; or
    b. If the plan of the Spouse, Former Spouse, or Dependent's employer permits participants to make an election for a period of coverage that is different from the Plan Year under this Plan.
12. **Addition or significant improvement of any Plan option** under the employer's Health Care Programs or your Spouse's employer's health care plans or programs. In such a case you may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.

These rules apply to making changes to your benefit coverage(s) during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status (for example, if mid-year, the employee and spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the spouse from coverage at this time) and
2. You must notify the Plan in writing within 31 days of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage; and
3. If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan; and
4. Coverage changes associated with a mid-year qualifying change of status opportunity **must be prospective** and therefore are effective the first day of the month following the qualifying change provided you submit a completed written enrollment/change form to the Employee Benefits Office, except for:
    - Newborns, who are effective on the date of birth;
    - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

GENERAL INFORMATION ON HEALTH OR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSA):

Termination of Employment and Affect On FSA: If you terminate your employment with the City during the year in which you have elected to participate in the FSA Plan, your rights to benefits will be determined as follows:

- **Dependent Care** – you may continue to request reimbursement for qualifying dependent care expenses for the rest of the plan/calendar year from the balance remaining in your Dependent Care account at the time of termination. However, no further salary contributions will be made.
- **Health Care** – participation in the Health FSA will cease and no further salary contributions will be made. However, you may submit claims for health care expenses incurred prior to your date of termination.

FSA Plan Accounting: Since these FSA programs are administered by the City of Mesa Employee Benefits Administration Office, all records and calculations are maintained in-house. The Benefits Office will provide each participating employee with periodic statements during the Plan Year that shows account balances and any activity on the account(s). If, at any time, you are unsure of your account balance, you may contact the Employee Benefits Administration Office.

Affect on Social Security Benefits: Participants in one or both of these plans may experience a slight reduction in Social Security benefits because, when you receive tax-free benefits under the Plan, the amount of Social Security Administration contributions made by both you and the City are reduced.

PROCEDURE FOR SUBMITTING FSA CLAIMS

Health (Medical and Dental) Claims:

1. If you have medical and/or dental coverage, there are two (2) steps to follow when submitting FSA claims:
    a) Submit the claim (or have the claim submitted by your provider) to the Employee Benefits Administration Office for processing. The Benefits Office will process the claim according to this Plan Document and will send any applicable payment to the appropriate party (provider or plan member). You will also receive an Explanation of Benefits (EOB) form detailing how the claim was processed.
    b) When you receive the Explanation of Benefits (EOB) form after your claims has been processed, complete a Health FSA Claim Form. Each expense submitted with the form must be itemized on the FSA claim form (do not write "see

attached"). Send the FSA form along with a copy of the EOB to the Employee Benefits Administration Office "Attention FSA."

c) If your out-of-pocket amount is a copayment, attach the original copayment receipt to your itemized FSA claim form. Cash register or charge card receipts are not acceptable for copayments.

d) If your expense is for a prescription filled through the City-sponsored pharmacy benefit management program, attach the original pharmacy receipt (that details the name and quantity of the prescription drug filled) to your itemized FSA claim form. Cash register or charge card receipts are not acceptable for prescription drug coinsurance or payment amounts.

2. If you have a health plan other than one of the City-sponsored plans, complete a Health FSA Claim Form and send it along with the copayment receipt(s) and/or receipt(s) for approved medical expenses*, to the Employee Benefits Administration Office "Attention FSA".

3. If your expense is for an **over-the-counter (OTC) medication**, you must submit the itemized cash register receipt that clearly states the name of the medication/product, date of purchase, name of the provider (drugstore, Dr.) and amount. If the receipt does not clearly state the item, you also must submit that portion of the packaging that includes the UPC code and name of the medication. Medical supplies such as bandages and tape or personal items such as dietary supplements beneficial for good health (e.g. vitamins), toothpaste or toothbrushes are NOT eligible expenses. OTC items that are considered dual-purpose need to have a note attached from a medical practitioner that describes the medical condition necessitating the OTC product.

**Approved medical and dental expenses are those expenses that qualify and are permitted by Section 213 of the Internal Revenue Code.*

Dependent Care Claims:

1. If you have eligible Dependent Care expenses, complete a Dependent Care FSA Claim Form and send it, along with a statement or receipt that specifically shows the type of service rendered (*i.e.*, Dependent Care), the name(s) of the dependent(s), dates of service, amount of expense incurred, and the name, address, and Tax Identification Number or Social Security Number of the service provider to the Employee Benefits Administration Office "Attention FSA".

2. A sample dependent care receipt form is available in the Employee Benefits Administration Office.

LIFE INSURANCE PROGRAMS

The City provides several Life Insurance policies for employees, including Basic Life Insurance, Accidental Death and Dismemberment Insurance and Commuter Life Insurance. The City of Mesa provides all full-time employees and elected officials with Basic Life Insurance, Accidental Death & Dismemberment (AD&D) coverage and Commuter benefits at no cost. This chapter briefly outlines information about the Life, AD&D and Commuter benefits; however for a more detailed explanation, refer to the insurance company handbooks (Certificate of Insurance) sent to you, and which is also available in the Employee Benefits Administration Office.

BASIC LIFE INSURANCE

Eligibility:

- **City Manager:** The Life Insurance plan covers the City Manager at 200% of annual salary rounded up to the nearest $1,000, to a maximum of $1,000,000.
- **Executive Pay Plan Employees:** Employees listed on the Executive Pay Plan will be covered at 150% of annual salary rounded up to the nearest $1,000. Executives may waive the additional 50% of coverage if desired.
- **Full-time Employees**: The Life Insurance plan covers full-time employees only, at 100% of annual salary rounded up to the nearest $1,000, with minimum coverage of $5,000. AD&D Benefits are provided at the same level of coverage as Life Insurance.
- **Elected officials:** These officials receive $50,000 in Life Insurance and AD&D coverage.
- **Dependents are not eligible for Basic Life and AD&D coverage.**

The name and telephone number of the Life Insurance/AD&D vendor is listed on the Quick Reference Chart in the Introduction chapter of this document.

Effective Date: Coverage will be effective on the first day of the month following one full month of employment. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to active work. Application for Life Insurance occurs at the time of a new hire with the City of Mesa. To apply for an extension of coverage due to total disability, contact the Employee Benefits Administration Office.

Beneficiary: If, as an employee covered under this Plan, you die while insured, the amount of Life Insurance Benefits as indicated above under Eligibility, will be payable to your beneficiary. When eligible employees enroll in the medical/dental/vision plans sponsored by the City of Mesa, a Life Insurance/AD&D beneficiary must be selected. A beneficiary must be selected **prior to** the effective date of coverage.

- **Changing the Beneficiary:** The beneficiary selected may be changed at any time on mesachip.mesaaz.gov or by completing a form available in the Employee Benefits Administration Office. Any change in beneficiary will become effective immediately.
- **Failure to Select a Beneficiary:** If you do not select a beneficiary, or if there is no named beneficiary living when you die, loss of life benefits will be paid in a lump sum to the survivors according to the guidelines of the life insurance company. If none of the above survives, benefits will be paid in a lump sum to your estate.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFIT

This benefit is provided to full-time employees at no cost. If, as an employee covered under this Plan, you die as a result of an accident, the amount of AD&D benefits provided will be equal to your annual salary rounded up to the nearest $1,000 and will be payable to the beneficiary of record. If, however, you receive a bodily injury covered by the AD&D plan, and have any loss named in the table below, benefits will be payable as shown in the table. The loss must:

(a) be caused exclusively by external and accidental means;

(b) be the result of the injury, directly and independently of all other causes; and

(c) occur within 90 days after the injury is sustained.

All benefits other than for loss of life will be paid to you.

SUPPLEMENTAL (Voluntary) LIFE INSURANCE

In addition to the Basic Life Insurance previously described, the City offers a Voluntary Life Insurance Plan to full-time and benefit-eligible part-time employees. You may elect to have yourself and your eligible family members covered under this Group Term Policy, with premiums automatically deducted from your biweekly paycheck. The name and telephone number of the Supplemental Life Insurance carrier is listed on the Quick Reference Chart in the Introduction chapter of this document.

As a new employee, you may elect to participate in this Plan at the same time you enroll in your medical and/or dental plans. The effective date of coverage will be the same as your health insurance effective date. For full-time employees, this usually occurs on the first day of the month following one month of employment, and for benefit-eligible part-time employees, on the first day of the month following 6 months of employment. All other employees may elect coverage under this Plan during the annual Open Enrollment period. The amount of coverage available to late enrollees is determined by the Life Insurance carrier.

Eligible dependents under this Plan include your legal spouse and dependent children **as defined by the carrier administering this plan**.

Beneficiary Selection: When you apply for coverage under this Plan, you must choose a beneficiary. Your beneficiary may be changed at any time by completing a Change of Beneficiary form available from the Employee Benefits Administration Office or by using the on-line Beneficiary option. Unless otherwise indicated, you will be beneficiary for your spouse and dependent children covered under this Plan.

Premiums: The monthly premium for the amount of life insurance coverage elected is payable biweekly through payroll deduction.

For additional information about the Life Insurance benefits under this Plan please refer to the Certificate of Coverage document available from the Life Insurance company.

COMMUTER LIFE INSURANCE

This policy provides a $200,000 death benefit to your beneficiary in the event that you are killed as a result of an accident that occurs while you are commuting to or from work with the City, using your normal route. This policy does not cover travel by aircraft.

SHORT TERM DISABILITY

Voluntary Short Term Disability (STD) is a benefit offered to employees by the City. This benefit is designed to protect a portion of your salary when you cannot work because of an accident, illness or pregnancy. Salary protection is available for up to 6 months, after the elimination waiting period. You may use your accrued sick and/or vacation leave until the waiting period is met, then STD benefits begin.

This chapter briefly outlines information about the Short Term Disability coverage; however, for a more detailed explanation, refer to the insurance company handbook (i.e. Certificate of Insurance) provided to you, and which is also available in the Employee Benefits Administration Office and online at InsideMesa.

Eligibility: Only full-time employees are eligible for this benefit.

Premiums: The STD premium is paid with after-tax dollars. It cannot be claimed on your Health Flex Account or taken as a deduction off your personal income taxes. The actual weekly STD benefit received under this Plan is not taxable income to you. Premiums are determined based upon your actual weekly salary and are payable through payroll deduction.

Benefits: There are three STD plan options:

- One with a 14-day elimination waiting period.
- One with a 29-day elimination waiting period.
- One with a 44-day elimination waiting period.

Please refer to the Short Term Disability Policy provided to the City
by the Short Term Disability vendor for more information.

LONG TERM DISABILITY (LTD)

The City of Mesa has two separate Long Term Disability (LTD) programs to cover employees: one for members of the Public Safety Personnel Retirement System (PSPRS) and another for members of the Arizona State Retirement System (ASRS). This document highlights some of the key aspects of these long term disability plans; however, the disability vendor's certificate dictates the exact benefits of the LTD plan.

Long Term Disability Income Insurance helps protect your income when, due to a covered illness or injury, you become disabled. The LTD plans described below cover disabilities occurring on or off the job. This important coverage helps to meet day to day living expenses during extended periods of disability, when your regular income has been discontinued and the need is greatest.

Long Term Disability Benefits are taxable income and are subject to applicable tax laws, including Arizona State tax. LTD vendors are required by Federal law to withhold twenty (20) percent of your monthly benefit for federal taxes. A Form W-2 will be sent to you at the end of the year reflecting taxes withheld for that year. **If you are exempt from taxes due to special circumstances, send a completed Form W-4 (to verify your exemption) to the LTD vendor each year.**

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM (PSPRS) MEMBERS:

Employees enrolled in the Public Safety Personnel Retirement System have Long Term Disability (LTD) coverage through a contracted disability vendor listed on the Quick Reference Chart in the Introduction chapter of this document. Benefits payable under this plan equal 60% of your base monthly earnings, reduced by benefits payable from other sources, with a maximum monthly benefit of $5,000 and a minimum benefit of $100. This coverage is provided at no cost to you.

ARIZONA STATE RETIREMENT SYSTEM (ASRS) MEMBERS:

Employees who are members of the Arizona State Retirement System have Long Term Disability (LTD) benefits available through the State Retirement System, using a contracted disability vendor to administer the program. The name of this disability vendor is on the Quick Reference Chart in the Introduction chapter of this document. This coverage is designed to provide a monthly benefit that partially replaces income lost during periods of total disability resulting from a covered injury, sickness or pregnancy. The cost of this coverage is determined by the Arizona State Retirement System and is deducted from your biweekly salary as a mandatory deduction.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Abutment: A tooth or root that retains or supports a fixed or removable bridge. See also the definition of Double Abutment.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source that is not work-related.

Active Course of Orthodontia Treatment: The period beginning when the first orthodontic appliance is installed and ending when the last active appliance is removed.

Actively At Work: You are considered to be actively at work when you are performing the regular duties of your employment in the customary manner either at one of the City's regular places of business or at some location to which the City's business requires you to travel. You are also considered to be actively at work on each day of a regular paid vacation, holiday, or non-working day on which you are not Totally Disabled, but only if you were performing the regular duties of your occupation in the customary manner on the regular work day immediately preceding that day. Note that this actively at work provision is not applicable to employees not at work due to a health condition.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow. When the services of an Acupuncturist is payable by this Plan, the Acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: Denial of payment of a claim in whole or in part; denial of coverage through utilization management; rescission of coverage; or written notification that a benefit is not covered under the plan.

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Plan Participant, except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. Examples of expenses or services that are not Allowable Expenses appear in the Exclusions chapter of this document.

Allowed Charge/Allowed Amount/Allowable Charge: means the amount this Plan allows as payment to non-network providers for eligible medically necessary services or supplies. The allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. Allowable charges may be applied to any out of network services.

The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed charge" amount for health care services or supplies.

Any amount in excess of the "allowed charge" amount does not count toward a Plan's annual deductible. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan. See also Contracted Amount.

With respect to **Non-network Emergency Room services**, the plan allowance is the **greater** of:

- the negotiated amount for in-network providers (the median amount if more than 1 amount to in-network providers), or
- 100% of the plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
- (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

Alternative Health Care Service: Refers to the following services acupuncture, homeopathy and naturopathy as those terms are defined in this plan. Refer to the Schedule of Medical Benefits for coverage guidelines.

Ambulance: means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is

a) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
b) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
c) provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated
d) or helpless and in need of immediate medical transportation; **or**
e) are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

Non-emergency medical services include transportation of individuals who cannot use public or private transportation because of their medically necessary requirement to be positioned in a wheelchair or stretcher. Non-emergency medical services are not payable by this Plan except under an approved alternate care plan in conjunction with case management.

Ambulatory Surgical Facility or Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
2. Where licensing is not required, it meets all of the following requirements:
   - It is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
   - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
   - It provides at least one operating room and at least one post-anesthesia recovery room.
   - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
   - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.
3. An Ambulatory Surgical Facility that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Specialized Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation either by a Physician (anesthesiologist) or Nurse Anesthetist.

Appliance: A dental device to provide or restore function or provide therapeutic (healing) effect. Fixed Appliance is a device that is cemented to the teeth or attached by adhesive materials. Prosthetic Appliance is a removable device that replaces a missing tooth or teeth.

Applied Behavior Analysis (ABA): is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior to attempt to improve speech and social interaction skills and reduce disruptive behavior. ABA is a technique used for individuals diagnosed with Autism Spectrum Disorder that refers to disorders defined in the DSM manual as autistic disorder, asperger's syndrome or pervasive developmental disorder. Applied Behavioral Analysis is not payable under this Plan.

Appropriate: See the definition of Medically Necessary for the definition of appropriate as it applies to healthcare services that are Medically Necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:

a. the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA), but not an employee of a hospital or surgical facility or a medical student, intern, or other trainee; and
b. the use of an assistant surgeon is determined by the Plan Administrator or its designee to be medically necessary; and
c. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between what this Plan pays and what the provider actually charged. Amounts associated with balance billing are not covered by this Plan, even if the Plan's Out-of-Pocket maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed or Contracted Charge. Note that amounts over the Allowed Charge do not count toward the Plan's Out-of-Pocket maximum and may result in balance billing to you. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Out-of-Network Health Care Providers commonly engage in balance billing a Plan participant for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid balance billing by using In-Network providers.**

Behavioral Health Disorder: A Behavioral Health Disorder is any Illness:

1. that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause, and, among other things, autism, depression, schizophrenia, and Substance Abuse.
2. where the treatment is primarily the use of psychotherapy or other psychotherapist methods, or is provided by Behavioral Health Practitioners as defined below.

Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage in the Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a certified mental health or substance abuse counselor or social worker who has a master's degree and who:

1. is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and
2. acts within the scope of his or her license; and
3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including Room and Board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for an Illness identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), are considered to be Mental Disorder treatments, except in the cases of multiple diagnoses. If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan. Outpatient prescription drugs of any kind are **not** considered to be Behavioral Health Treatment for the purposes of this Plan, such medications are payable under the participant's medical plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which fully meets one of the following two tests:

1. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
2. Where licensing is not required, it meets all of the following requirements:
   - have at least one Physician on staff or on call; and
   - provide skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN); and
   - prepare and maintain a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.
3. Behavioral health treatment in either a free-standing Behavioral Health Facility or the Behavioral Health unit of a Hospital is payable under the Behavioral Health benefits of this Plan.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the allowable or contracted charge, after calculation of all Deductibles, Coinsurance, Copayments and Allowed or Contracted Charges, and after determination of the Plan's exclusions, limitations and maximums.

Benefits Administrator: See the definition of Plan Administrator.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
   - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
   - It has available, trained personnel and necessary equipment to handle foreseeable emergencies, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - It provides at least 2 beds or 2 birthing rooms.
   - It is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It has the capacity to administer local Anesthetic and to perform minor Surgery.
   - It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
   - It is expected to discharge or transfer patients within 48 hours following delivery.
3. A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Bitewing X-Rays: Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Body Mass Index (BMI): BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared:

BMI = (weight in kilograms)
divided by (height in meters) times (height in meters)

or compute using the Obesity Education Initiative website: http://www.nhlbisupport.com/bmi/

To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Bridge, Bridgework: A fixed or removable prosthesis that replaces one or more teeth, is cemented in place to existing abutment teeth, consists of one or more pontics and one or more retainers (Crowns or Inlays), and cannot be removed by the patient. A removable prosthesis is held in place by clasps and can be removed by the patient.

Buccolingual: A dental term referring to the surfaces of a tooth facing the cheek or mouth (buccal) and the tongue (lingual).

Calendar Year: The 12-month period beginning January 1 and ending December 31. All annual Deductibles and Annual Maximum Plan Benefits are determined during the calendar year. See also the definitions of Contract Year and Plan Year.

Case Management: A process, administered by the Utilization Management Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, and the Benefits Administrator to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Certified Surgical Assistant (CSA, SA-C): A person who is at least a high school graduate and who has successfully passed a national surgical assistant program. A CSA does not typically hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Nurse Midwife, Podiatrist, Dentist, MD or DO. A CSA may or may not be required to be licensed by a state agency. A CSA assists the primary surgeon with a surgical procedure in the operating room and is not an employee of a health care facility. Such individual may be payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA, SA-C), Certified Surgical Technologist (CST), Certified First Assistant (CFA), Certified Surgical Technologist (CST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT) **only IF** the use of an assistant surgeon is medically necessary.

Chemical Dependency: See the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren) under the Dependent definitions heading.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

City: The City of Mesa.

Claim Review Fiduciary: A person or company retained by the Plan and designated in the Plan documents to review and reconsider claims that have been denied in whole or in part if and when you or any similarly situated Plan participant requests such a review. See the Appeal Process in the Claim chapter of this document.

Claims Administrator: A person or committee maintained by the Plan to administer the claim payment responsibilities of the Plan. For example, the Claims Administrator for the dental plan is the City of Mesa's Employee Benefits Administration Office however the Claims Administrator for vision benefits is the contracted Vision Plan. There may be more than one Claims Administrator for this Plan because of the variety of benefits offered under this Plan.

Contract Year: The period of time designated in the contract between the City of Mesa and the vendor providing the service.

Contracted Charge/Contracted Amount: means the amount this Plan allows as payment for eligible medically necessary services or supplies to PPO network providers. With respect to a network provider (PPO network Health Care or Dental Care provider/facility), the Contracted Amount is the negotiated fee/rate set forth in the agreement between the participating network Health care or Dental care provider/facility and the PPO network or the Plan. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Contracted Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-network claim; or the Health care or Dental care provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based upon the Health care or Dental care provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible or Coinsurance. This is because the Plan covers only the "contracted charge" amount for health care services or supplies.

Any amount in excess of the "contracted charge" amount does not count toward the Plan's annual Out-of-pocket maximums. Participants are not responsible for amounts that exceed "contracted charges" amount by this Plan.

In the case where the PPO allowed charge amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed charge amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed charge amount versus the actual billed charges. See also Allowed Charges.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan Benefits are payable when a person is covered by two or more employer-sponsored health care plans. See the chapter on Coordination of Benefits that sets forth the Plan's COB rules and procedures.

Copayment, Copay: The set dollar amount you are responsible for paying when you incur an Eligible Medical or Vision expense for certain services, generally those provided by in-network providers.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or reduction other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medical Necessity for the definition of Cost-Efficient as it applies to healthcare services that are Medically Necessary.

Covered Individual: Any employee, retiree, Elected Official or COBRA participant and that person's Spouse or Dependent Child (as those terms are defined in this Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Crown: The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Custodial Care: Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

Deductible: The amount of Eligible Medical or Dental Expenses you are responsible for paying before the Plan begins to pay benefits. **Individual Deductible:** The amount one covered person must pay before the Plan begins to pay benefits for that person. **Family Deductible:** The amount that an entire family must pay before the Plan begins to pay benefits for the family members. The family deductible is equal to three (3) individual deductibles but is calculated based upon the amounts applied to the deductible by all family members. See also the Medical Expense and Dental Expenses chapters in this document. There is also a separate deductible applied to non-network services and retail prescription drugs. See the Schedule of Medical Benefits in this document.

Dental: Dental services and supplies are **not** covered under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise. As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics, but **not** including outpatient prescription drugs, prescribed by a Dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dental Care Provider: A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Hygienist: A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty	Diagnosis, Treatment or Prevention of Diseases Related To:
Endodontics	the dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of children.
Periodontics	structures that support teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial appliances for the mouth (Bridges, Dentures, Crowns).

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; **and** acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Denture: A device replacing missing teeth.

Dependent(s)

Dependent Child(ren): For the purposes of this Plan, a Dependent Child is any of the employee/retiree's children listed below who are **under the age of 26 whether married or unmarried**:

- natural children (son or daughter),
- foster children,
- stepchildren,
- legally adopted child(ren) or children placed for adoption,
- child(ren) for whom the employee or retiree is the legal guardian,
- child named in a qualified medical child support order (QMCSO) is also an eligible Dependent Child under this Plan.

A **Disabled Adult Child** may continue coverage if they are an **unmarried** Dependent Child (as defined above) **age 26 or older** who is **permanently and totally disabled** with a disability that existed prior to the attainment of the Plan's age limit. The Plan will require initial and periodic proof of disability. Proof of Social Security Disability is required for children over age 26. A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan. "Disabled" means the inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise totally Disabled.

It is the employee's or retiree's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent Child are NOT met with respect to any child for whom coverage is sought or is being provided.

Coverage of a Dependent Child ends at the end of the month in which that child:

1. reaches his or her 26th birthday, unless the child is a Disabled Adult Child (as described above),
2. becomes employed in a full-time benefit eligible position by the City of Mesa, **or**
3. fails to pay required contributions for coverage,
4. no longer meets the definition of a Dependent child.

The following individuals are not eligible under the Plan: a spouse of a Dependent Child (e.g., the employee/retiree's son-in-law or daughter-in-law) and grandchild (unless the employee/retiree is the legal guardian of the grandchild.

Eligible Dependent: Your lawful Spouse (as defined in this Plan) and your Dependent Child(ren). An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Spouse: The employee's lawful spouse as determined by Arizona State law. For 6 months following the death of an employee, eligible dependents may continue benefit coverage under this Plan. Thereafter, they may elect COBRA coverage (exludes provisions of Harrolle's Law).

Disabled: A physical or mental impairment that substantially limits one or more of that person's major life activities. Major life activities typically refer to employment, caring for oneself, walking, learning, breathing, speaking, hearing, or seeing. See also the definition of Totally Disabled.

Double Abutment: Tying two teeth together to help support a Bridge. If there is bone loss due to periodontal disease (pyorrhea), this will be considered a form of Periodontal Splinting. See the definition of Periodontal Splinting.

Durable Medical Equipment: Equipment that:

1. can withstand repeated use; and
2. is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and
3. is not disposable or non-durable.

Durable Medical Equipment includes, but is not limited to: apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails) electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: See the definition under the **Dependent Definitions** heading.

Eligible Expenses: Expenses for healthcare services or supplies, but only to the extent that:

1. they are Medically Necessary, as defined in this Definitions chapter of the document; and
2. the charges for them are Allowed or Contracted Charges, as defined in this Definitions chapter of the document; and
3. coverage for the services or supplies is not excluded, as provided in the Exclusions and Definitions chapters of this document; and
4. the General Overall, Limited Overall, and/or Annual Maximum Plan Benefits for those services or supplies has not been reached.

Emergency Care: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services: means with respect to an emergency medical condition (defined below), a medical screening examination within the **emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).
- The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by the City who is eligible to enroll for coverage under the Plan.

Employee Benefits Administrator: Same as the Plan Administrator.

Employer: The City of Mesa.

Enroll, Enrollment: The process of completing and submitting a written enrollment form to the City of Mesa indicating that coverage by the Plan is requested by the Employee or Retiree. An Employee or Retiree may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding enrollment.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Medical and Dental Plan Exclusions chapters of this document, for which the Plan does **not** provide Plan Benefits.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter of this document.

Experimental and/or Investigational:

A. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; **and** written by experts in the field that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA):
   - FDA approval is required in order for the service and supply to be lawfully marketed; **and** it has not been granted at the time the service or supply is prescribed or provided; **or**
   - A current investigational new drug or new device application has been submitted and filed with the FDA.
5. However, a drug will **not** be considered Experimental and/or Investigational if it is:
   - approved by the FDA as an "investigational new drug for treatment use"; **or**
   - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; **or**
   - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **not** approved for general use, **and** the FDA has **not** determined that such drug should not be prescribed for a given type of cancer.
6. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

B. In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed or provided, or the service or supply was considered for precertification under the Plan's Utilization Management program:**
   1. Medical or dental records of the covered person;
   2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
   3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
   4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to:
      - "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
      - The published opinions of:
        - the American Medical Association (AMA),. clinical policy bulletins of major insurance companies in the US such as Aetna or CIGNA or Milliman Care Guidelines; or
        - specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
   5. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
   6. The latest edition of "The Medicare National Coverage Determinations Manual."

C. To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational, see the section on Precertification Review in the Utilization Management chapter of this document.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Federal Legend Drugs: See the definition of Prescription Drugs.

Fluoride: A solution applied to the surface of teeth or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Generic (drug): A generic drug is a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use. Generic drugs work in the same way and in the same amount of time as brand-name drugs. Generic drugs typically provide substantial dollar savings as compared to brand name drugs.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Gnathologic Recording: A measurement of force exerted in the closing of the jaws.

Handicap or Handicapped (Physically or Mentally): See the definition of Disabled and Totally Disabled.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions chapter.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Heath Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following tests:

1. It is approved by Medicare; or
2. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home and
    - it has a full-time administrator and it is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs) and
    - it maintains written clinical records of services provided to all patients and
    - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available and
    - its employees are bonded and
    - it maintains malpractice insurance coverage and
    - it is established and operated in accordance with applicable licensing and other laws.

Homeopathy: A school of medicine based on the theory that large doses of drugs that produce symptoms of an Illness in healthy people will cure the same symptoms when administered in small amounts. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." When the services of Homeopaths are payable by this Plan, the Homeopath must be properly licensed to practice Homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following:

1. It is approved by Medicare; **or**
2. It is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
   - It provides 24 hour-a-day, 7 day-a-week service;
   - It is under the direct supervision of a duly qualified Physician;
   - It has a full-time administrator;
   - It has a nurse coordinator who is a Registered Nurse (RN) with 4 years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
   - The main purpose of the agency is to provide Hospice services;
   - It maintains written records of services provided to the patient;
   - It maintains malpractice insurance coverage;
   - A Hospice that is part of a Hospital, as defined in this Chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:
1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
2. is approved by Medicare as a Hospital; and
3. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.
4. A Hospital may include facilities for behavioral health treatment that are licensed and operated according to law.
5. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Convalescent Care Facility, Extended Care Facility, Hospice, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or for the aged will **not** be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered employee, retiree or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan. However, infertility is **not** an Illness for the purpose of coverage under this Plan.

Immediate Temporary Denture: A temporary Denture that is placed immediately after the extraction of teeth.

Implantology: The science of placing artificial root structures on or within the jawbones that will act to hold and support a dental prosthesis.

Impression: A negative reproduction of the teeth and gums, from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source or an intrinsic force, such as the force of biting or chewing. Benefits for Injury to Teeth are payable under the Medical Plan.

Inlay: A Restoration made to fit a prepared tooth cavity and then cemented into place.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Non-Network Services that are provided by a Health Care Provider that is **not** a member of (under contract with) the PPO.

Inpatient Services: Services provided in a Hospital or other Specialized Health Care Facility during the period when charges are made for room and board.

Intensive Outpatient Program (IOP): Intensive outpatient program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three hours per day, a minimum of three days per week and a minimum of nine hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational: See the definition of Experimental and/or Investigational.

Lifetime Benefit: This term **does not** denote, nor should it be construed to denote, any obligation by the Plan to pay any Benefits for the lifetime of the Plan Participant. Rather, it is a popular term that describes the maximum amount of Benefits payable by the Plan during the entire time a Plan Participant is covered under this Plan and any previous medical and/or dental expense plan provided by the City. See the definitions of Maximum Plan Benefits.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Mandibular Disorders: Disorders of the lower jaw.

Maxillary Disorders: Disorders of the upper jaw.

Maximum Plan Benefits: The maximum amount of Benefits payable by the Plan on account of medical and/or dental expenses incurred by any covered Plan Participant under this Plan and any previous medical and/or dental expense plan provided by the City. The General and Limited Overall Maximum Plan Benefits are often referred to as "Annual" Benefits, but this reference **does not** denote, nor should it be construed to denote, any obligation by the Plan to pay any Benefits for the a full year for the Plan Participant.

- **Annual Maximum Plan Benefits** are the maximum amount of Benefits payable each Calendar Year on account of certain medical and/or dental expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan and any previous medical and/or dental expense plan provided by the City during that calendar year.

Medically Necessary:

A. A medical, dental, vision or behavioral health service or supply will be determined to be "Medically Necessary" by the Plan Administrator or its designee if it:
   - is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   - is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted medical standards in the community in which it is provided; and
   - is determined by the Plan Administrator or its designee to meet all of the following requirements:
     - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
     - It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and
     - It is an "Appropriate" service or supply given the patient's circumstances and condition; and
     - It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and
     - It is safe and effective for the illness or injury for which it is used.

B. A service or supply will be considered to be "Appropriate" if:
   - It is a diagnostic procedure that is called for by the health status of the patient, and is:
     - as likely to result in information that could affect the course of treatment as; and
     - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   - It is care or treatment that is:
     - as likely to produce a significant positive outcome as; and
     - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A service or supply will be considered to be "**Cost-Efficient"** if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician, Healthcare Practitioner or Dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the coverage provided by the Plan.

E. A Hospitalization or confinement to a Specialized Health Care Facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and Appropriately be diagnosed or treated while not confined.

F. A service or supply that can safely and Appropriately be furnished in a Physician's, Healthcare Practitioner's, or Dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or Specialized Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Specialized Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will **not** result in a determination that continued confinement in a Hospital or other Specialized Health Care Facility is Medically Necessary.

H. A service or supply will **not** be considered to be Medically Necessary if it **does not require** the technical skills of a Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, or any Hospital or Specialized Health Care Facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administering intravenous fluids and certain medications, providing emergency measures while awaiting aid, performing newborn evaluation, signing birth certificates, and billing and being paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A nurse midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea. When the services of Naturopaths are payable by this Plan, the Naturopath must be properly licensed to practice Naturopathy in the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, must be a qualified Health Care Practitioner or Physician or hold a degree as a Doctor of Naturopathic Medicine from a school approved by the Council on Naturopathic Medical Education, or have successfully graduated with a diploma of Doctor of Naturopathic Medicine and completed a post graduate clinical training program approved by the Council on Naturopathic Medical Education.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those nondurable supplies that are identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network (out-of-network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Non-Participating Provider: A Health Care Provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP) or Registered Nurse Practitioner (RNP), and authorized, in collaboration with a Physician, to examine patients and establish medical diagnoses; admit patients into Health Care Facilities; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and refer to and consult with appropriate Health Care Practitioners; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT coding. Neither a

telephone discussion with a Physician or other Health Care Practitioner nor a visit to a Health Care Practitioner's office **solely for** such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Onlay: An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Open Enrollment Period: The period during which participants in the Plan may select among the health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is designated in advance by the Plan Administrator or its designee.

Orthodontics, Orthodontia: The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or TMJ syndrome/dysfunction. See the definitions of TMJ syndrome, Prognathism and Retrognathism.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Out-of-Network Services: See Non-Network.

Out-of-Pocket Maximum: The maximum amount of Coinsurance each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional Covered Expenses for the remainder of the Calendar Year. For a list of expenses that do not count toward the Out-of-Pocket Maximum, see the section on Out-of-Pocket Maximum in the Medical Benefits chapter of this document.

Outpatient Services: Services provided either outside of a Hospital or Specialized Health Care Facility setting or at a Hospital or Specialized Health Care Facility when room and board charges are **not** incurred.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The Denture may be removable or fixed.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Periodontal Splinting: Tying two or more teeth together when there is bone loss. This is done to gain additional stability for teeth that can no longer stand alone.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Physician Assistant: A person legally licensed as a Physician Assistant and authorized, under the supervision of a Physician, to examine patients and establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and refer to and consult with the supervising Physician; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter of this document.

Plan Administrator: The person designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan. The City of Mesa Employee Benefits Administrator is the Plan Administrator.

Plan Participant: Any employee or retiree and that person's Spouse or Dependent Child (as those terms are defined in this Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Plan, This Plan: The program, benefits and provisions described in this document.

Plan Year: The twelve-month period from January 1 to December 31 is designated to be the Plan Year. The Contract Year may not be the same as the Plan Year. See also the definitions of Calendar Year and Contract Year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Practitioner: See the definition of Health Care Practitioner.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled Hospital admission or outpatient Surgery.

Precertification (also called prior authorization, preauthorization, pre-approval, preservice review): A managed care program designed to assure that services are medically necessary before the service is provided. For example, under the Medical Plan, hospital admissions and certain other health care services are subject to review by the Utilization Management (UM) Company before services are provided (see the Utilization Management chapter for details) while the Prescription Drug Program reviews certain drugs/medications before the prescription is filled (contact the Prescription Drug Program at their phone number on the Quick Reference Chart in the front of this document).

Preferred Provider Organization (PPO): A group or network of Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates as payment in full, except with respect to a defined copayment or coinsurance for which the covered employee, retiree or dependent is responsible.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drugs:** Any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a Dentist or Dental Hygienist.

Prosthesis (Dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Provider: See the definition of Health Care Provider.

Psychiatric: See Behavioral Health Disorder.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that Benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child.

Reconstructive Surgery: A Medically Necessary Surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy on account of a malignancy.

Rehabilitation Therapy: Cardiac, occupational, physical, pulmonary or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed Therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care, and then only until the patient is capable of being discharged from the Hospital because Hospitalization for the condition requiring acute Hospital care is no longer Medically Necessary. Continued Hospitalization for the primary purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan. This plan does not provide payment for admission and confinement in an inpatient rehabilitation facility to provide rehab services to a person who currently has a cognitive deficit (that is, the person is unable to learn and remember the services being taught to them).

Restoration: A broad term applied to any filling, Crown, Bridge, Partial Denture or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retail Medical Clinics: Walk-in clinics in retail stores like pharmacies and supermarkets, staffed by nurse practitioners and provide high-quality care for routine illnesses. These retail medical clinics are usually open on evenings and weekends offering one-time care and standard interventions to a limited range of health needs at low cost. Retail medical clinics are NOT equipped to diagnose or deal with complex cases. They are not doctors, nor are they structured to follow-up on treatment or offer many diagnostic tests.

Retiree: There are four groups of retirees:

- **Prior to November 1, 1991** retired employees of the City of Mesa who did not have to fulfill the requirement of having **at least 10 years** of service with the City of Mesa.
- **Beginning November 1, 1991**, and for those employees hired on or before **December 31, 2000,** retired employees (retirees) of the City of Mesa with **10 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify **and** begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System (PSPRS) on the first of the month following retirement with the City of Mesa.
- **Effective January 1, 2001**, retired employees of the City of Mesa hired on or after January 1, 2001 through December 31, 2005 with **15 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify **and** begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System on the first of the month following retirement with the City of Mesa.
- **Effective January 1, 2006**, retired employees of the City of Mesa hired on or after January 1, 2006 with **20 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify and begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System on the first of the month following retirement with the City of Mesa.
- **Effective January 1, 2009,** retired employees of the City of Mesa who were hired on or after January 1, 2009 are not eligible for retiree benefit coverage, except as the Special Rules for **RIWF**, noted below, may apply.

Retired employees (retirees) also include those individuals who have retired from City of Mesa employment due solely to a disability (totally disabled for a period of at least 6 months) **and** are receiving a LTD benefit **and** who continue to meet the requirements of disability as defined in the Definitions chapter of this document.

If a FT or PT retiree comes back to work as a PT Active employee, he/she will remain as a retiree for health insurance purposes.

If a retiree returns to FT active employment, he/she will return to active status and pay active employee premiums. If the employee is an ASRS retiree, he/she will receive a subsidy reimbursement from the retirement system once every 6 months,

PSPRS employees receive NO subsidy payment. When the employee returns to retired status, he/she will do so without regard to this additional employment (i.e. his/her hire date will remain the same as before and he/she will not accrue any additional year of service for the purposes of determining premium payment amounts).

If a person terminates employment with the City and at a later date is rehired by the City, the most recent hire date will be used for calculating the years of enrollment required to continue benefits as a Retiree. Previous years of services will not be used to calculate years of service for purposes of calculating eligibility or premium amounts.

Retirees eligible for Medicare must enroll in both Part A and Part B; Part D is optional.

Seasonal employment (not a benefits-eligible position) does not qualify toward benefits eligibility under this Plan.

Note that employees hired on or after 1-1-09 are not eligible for retiree benefit coverage, except as the Special Rules for RIWF, noted below, may apply.

SPECIAL RULES PERTAINING TO REDUCTION IN WORK FORCE (RIWF): Effective for RIWF's occurring on or after January 1, 2009, if an employee's position has been targeted for reduction, and as a result the employee occupying that position either accepts a severance package or early retirement, and if, within two years from the last day worked, said employee is rehired by the City of Mesa, the following will apply for purposes of determining retiree health insurance eligibility:

a. The employee's last prior employment effective date with the City of Mesa will be reinstated to determine the number of years of service required for that employee to qualify for retiree benefits upon retirement from the City.

b. The employee's prior years of service with the City of Mesa (including partial years) will be reinstated and used as credit toward the City's years of service requirement for determining eligibility and family premium amount.

c. These provisions do not apply to City of Mesa employees accepting voluntary severance whose positions were not targeted for reduction in work force (layoff).

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are Allowed or Contracted Charges.

Root Canal (Endodontic) Therapy: Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scale: To remove calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing a Surgery or receiving a medical service.

Skilled Nursing Care: Services performed by a licensed Nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a Nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a Nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
7. It is not a hotel or motel.
8. A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialized Health Care Facilities: For the purposes of this Plan, Specialized Health Care Facilities include Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions chapter.

Specialty Care Unit: A section, ward, or wing within a Hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Specialty Drugs: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injectable, require an infusion, must be administered by a health care practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before self-administration, and/or unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Specialty drugs are managed by the Prescription Drug Program under contract to the Plan. Examples of specialty drugs can include certain medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by a Physician.

Spouse: See the definition under **Dependent** heading.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, generally not to exceed 60 days, to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of **Behavioral Health Disorders** and **Chemical Dependency**.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed or Contracted Charge will be allowed as the Plan's Benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of Allowed or Contracted Charge
Secondary and additional procedures	50% of Allowed or Contracted Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of Allowed or Contracted Charge

First site secondary and additional procedures	50% of Allowed or Contracted Charge per procedure
Second site primary and additional procedures	50% of Allowed or Contracted Charge per procedure

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician or Chiropractor, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee. For further information, see the definition of Occupational, Physical and Speech Therapy.

Third Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the Second Opinion indicates that the recommended Surgery or medical service is not Medically Necessary

Topical: Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Total Disability, Totally Disabled: For an eligible employee, Total Disability means that during the first two years of disability the Eligible Employee is prevented, solely because of an injury or disease, from engaging in his/her regular or customary occupation and is performing no work of **any** kind for compensation or profit. After the first two years of disability, the eligible employee must be unable to engage in **any** occupation for which he is reasonably fitted by education, training or experience. The final determination as to whether or not Total Disability exists will be made by a Physician and approved by the appropriate Long Term Disability carrier. Any eligible employee not meeting the definition of disability who does not qualify as a retiree will not be eligible for benefits, unless under COBRA legislation. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

1. **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
2. **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
3. **Xenographic** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are **not** covered by this Plan.

See the Schedule of Medical Benefits and the Exclusions chapter of this document for additional information regarding Transplants. See also the Utilization Management chapter of this document for information about precertification requirements for transplantation services.

Urgent Care Facility: A public or private Hospital-based or free-standing facility, that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management (UM): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services or the medical necessity and appropriateness of certain prescription drugs. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation.

Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan. Precertification of certain prescription drugs is performed by the Prescription Drug Program.`

Utilization Management Company: The independent utilization management organization, staffed with licensed health care professionals, operating under a contract with the Plan to administer the Plan's Utilization Management services.

Visit: See the definition of **Office Visit**.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be Medically Necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Baby Care is set forth in the Preventive Services Section of the Schedule of Medical Benefits chapter of this document.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do **not** refer to any Dependent of the employee or retiree.

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